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SMALL BUSINESSES AND HEALTH INSURANCE: EASING COSTS AND EXPANDING ACCESS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON

EXAMINING EASING COSTS AND EXPANDING ACCESS RELATING TO SMALL BUSINESSES AND HEALTH INSURANCE, FOCUSING ON S. 406, TO AMEND TITLE I OF THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 TO IMPROVE ACCESS AND CHOICE FOR ENTREPRENEURS WITH SMALL BUSINESSES WITH RESPECT TO MEDICAL CARE FOR THEIR EMPLOYEES

APRIL 21, 2005

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SMALL BUSINESSES AND HEALTH INSURANCE: EASING COSTS AND EXPANDING ACCESS

THURSDAY, APRIL 21, 2005

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in Room 430, Dirksen Senate Office Building, Hon. Mike Enzi, chairman of the committee, presiding.

Present: Senators Enzi, Burr, Isakson and Ensign.

OPENING STATEMENT OF SENATOR ENZI

The CHAIRMAN. I officially call this hearing to order. Good morning and welcome.

As just about every worker and employer knows, there are few issues that are of greater importance to both groups than access to healthcare at an affordable price, and for America's small businesses and their workers, worries about healthcare are becoming acutely important. That is why we have called today's hearing.

We are here to examine the ways of addressing the serious and growing problems facing small businesses in offering affordable coverage to their employees and their families. As we meet today we have had almost 5 full years of devastating double digit growth in health insurance premiums, and we have seen increases of more than 5 times the rate of inflation. Since 2000 premiums for family coverage have grown nearly 60 percent compared to an inflation rate of 9$^{7}/_{10}$ percent over the same period. Employers want very much to keep offering coverage, and they are struggling to maintain current coverage levels. The big worry is how much longer can the system sustain double digit cost growth before it begins to seriously unravel.

As chairman of this committee one of my goals will be to achieve serious and meaningful reform in the small business health insurance system. Simply put, we need to develop an effective yet reasonable strategy to increase the ability of small and low-wage businesses to offer health insurance.

As a former small business owner I have seen this problem firsthand. My own State of Wyoming recently ranked 47th in the percentage of businesses that offer health insurance to their employees.

I know there is a passionate debate on how to reform the small group insurance market in States where limited competition exists.

On the one hand, advocates for association health plans, AHPs, make a strong and persuasive case that small businesses should be able to pool their purchasing power and thereby reap some of the advantages currently enjoyed by large employers. Such advantages, many argue, would include greater bargaining power, economies of scale and administrative efficiencies. You have to find a lot of merit in those ideas. Nevertheless, I am also mindful that critics have raised some very serious concerns that going this route could trigger dangerous adverse selection and fracture an already-fragmented market. Whatever we do we need to ensure that the insurance market is stable and that consumers are protected.

It is my intention as chairman to work closely with both opponents and proponents of AHPs toward the goal of easing the cost and expanding the access to small business health insurance. As we do, my colleagues and I also will be taking a careful look at some of the alternative approaches that have been suggested, such as encouraging greater harmonization of what is often called a patchwork of State insurance laws and regulations, or easing costly benefit mandates. The one option I will not accept is doing nothing.

For those who oppose AHPs now is the time to come forward with constructive alternatives, and for AHP supporters now is the time to think seriously about ways to bridge the differences that remain on the important issues.

We have with us today an impressive group of witnesses, well-equipped to help us sort out these thorny issues, including one of my constituents, Mitch Blake, a small business owner from Jackson, Wyoming. I know that each of you has strongly-held views, and an airing of those views is very important. However, I would ask whenever possible, that you help us to focus on possible alternatives and practical solutions that may go beyond the particular perspective of the constituency that you represent.

I look forward to today's discussion, and we welcome your contribution to it.

When Senator Kennedy shows up we will allow an opportunity for his opening statement. As the tradition is with the committee, the chairman and the ranking member are recognized to deliver opening statements. I do ask unanimous consent that any opening statements from my colleagues be entered into the record. Without objection, so ordered.

So we will now hear from our first panel of witnesses. We will introduce the witnesses all at once, and then I will ask you while I am doing that to think about summarizing your statement so it gives more time for questions.

I am especially pleased to introduce Mr. Mitchell Blake as the first member of our panel. Mr. Blake is joining us from my home State of Wyoming. He operates Ward & Blake Architects, an 8-person architectural firm in Jackson, Wyoming. Ward & Blake has been featured in several national publications, and has received awards from the Wyoming Chapter of the American Institute of Architects. Mr. Blake is here representing the millions of small businesses across the country, the vast majority of which are facing ever-increasing insurance costs for their employees. As a small business owner he will describe the impact that dramatic premium increases have had on his company and the challenges the com-

pany has faced in providing coverage for an employee whose child suffered from an expensive and serious illness.

Joseph Rossmann is the Vice President of Fringe Benefits for Associated Builders and Contractors, Inc., ABC, a national trade association made up of commercial contractors and located in Arlington, Virginia. He has worked in association health and welfare insurance programs for the past 27 years. Mr. Rossmann will discuss the ongoing and frustrating efforts of his organization to offer health insurance to employees through its association. He will also represent the views of the Association Health Care Coalition.

Karen Ignagni is the Chief Executive Officer of America's Health Insurance Plans, AHIP. She has led the organization since 2003 and has long been a leader in the healthcare field. Among other accomplishments, she is the author of more than 90 articles regarding healthcare policy issues. She is here today to offer the perspective of American insurers on the coverage problems facing small business. We especially look forward to her and AHIP's thoughts regarding ways these problems can be effectively addressed.

Finally, we are joined today by Sandy Praeger, the Insurance Commissioner of the State of Kansas. She is also here to speak on behalf of the National Association of Insurance Commissioners, NAIC. Sandy Praeger currently serves as the Commissioner of Insurance for the State of Kansas. She is responsible for overseeing nearly 1,700 insurance companies and 65,000 agents licensed to do business in the State. She also serves as Secretary Treasurer of the National Association of Insurance Commissioners. Before being elected as an insurance commissioner, Commissioner Praeger served more than a decade in the Kansas Senate, where she assumed a leadership role on healthcare and insurance issues. We look forward to her testimony offering the perspective of our State insurance regulators, all of whom are serving on the front lines in addressing small business insurance challenges.

I thank all of you for being here today. I look forward to hearing constructive suggestions about ways to address the serious challenges facing small business and healthcare. Your full statement will be a part of the record, so any summarization that you can do will be greatly appreciated.

Mr. Blake?

STATEMENTS OF MITCHELL BLAKE, WARD & BLAKE ARCHITECTS, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS; JOSEPH E. ROSSMANN, VICE PRESIDENT OF FRINGE BENEFITS, ASSOCIATED BUILDERS AND CONTRACTORS, INC. ON BEHALF OF THE ASSOCIATION HEALTH PLAN COALITION; KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS; SANDY PRAEGER, COMMISSIONER OF INSURANCE, STATE OF KANSAS, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. BLAKE. Good morning, Mr. Chairman. Thank you for inviting me here to speak on the subject of affordable health insurance, especially as it applies to small business. I am pleased to represent the NFIB here——

The CHAIRMAN. You need to move it just a little closer.

Mr. BLAKE. Excuse me. I am pleased to be here on behalf of NFIB, representing small businessmen with similar concerns as myself concerning the health insurance.

You have done a good job of introducing my firm. You may be familiar with some facilities that we have designed, one being the Nature Conservancy at Red Canyon Ranch in Lander, Wyoming, the other being the main facility at Spring Creek Ranch resort in Jackson, Wyoming.

We have been trying to create a relaxed environment. I feel that providing healthcare for my employees is one way that I can do this, to give them some peace of mind and help them feel confident that their insurance needs will be met. This was not a troubling task when we started our firm in 1996.

We went for a few years with Blue Cross insurance until the premiums started to escalate and we could no longer afford to stay with that company. We then switched to Life Investors Insurance Company of America, and we were with them for a couple of years until they decided to pull out of the health insurance in Wyoming, and so they gave us an 18-month withdrawal period. We thought we would renew with them but their premium increased from 2,800 a month to nearly 4,800 a month, and my company was not able to absorb that.

We switched to John Alden Life Insurance at this point, and things were okay for a year, but in October of 2002 I had an employee find out that his 3-year-old daughter had a malignant brain tumor in the base of her skull. He was devastated. So we told him to take as much time as he needed to to deal with the situation. He spent 3 months at Primary Children's Hospital in Salt Lake City going through tests, and the whole time we continued to pay him full salary while he was gone. He then returned to the company for another 3 months on a half-time basis while he continued with follow-up tests, and we continued to pay him full salary on the half-time basis.

When it came time for our premium renewal, John Alden increased our premiums by $1,200, which was a significant increase over the 2,000 that we were paying. In order to get the insurance affordable we raised our deductibles from $500 to 1,000, and increased the out-of-pocket maximum slightly. We agreed to this. We sent in our premium check on December 19th, and then we sent in the subsequent month premium check on December 31st. On January 6 of 2004, which was just the following month, we were notified that we were terminated as a group. We were upset. When we received the notification we checked with the bank. Our check had cleared for the December premium. Then subsequently on January 14th our second check for the January premium had cleared the bank also. We were upset about this.

Our insurance agent got with the Wyoming Health Insurance Commission. They pressured John Alden into reaccepting our group, however, they would only accept us as a new group, and they added another 40 percent to the premium that we had just agreed to accept, which was more than my company was able to bear. So we declined the offer.

In the interim period I had to find a bridge plan to keep my employees covered until I could find new insurance. In addition, I of-

fered them 100 percent coverage for any medical expenses they had during the months that we were not insured.

We then found out about the WHIP Plan, the Wyoming Health Insurance Pool or Wyoming Health Insurance Plan, and we found that my employee's daughter qualified for that plan. So we moved her onto that plan, and reapplied to Starmark Insurance as a new group without her as part of our group. We got a more affordable premium at $2,350 a month for my 8 employees and with $1,000 deductible.

When it came time to renew our premium again this year we were hit with another $800 a month increase, nearly $10,000 a year, which was a big hit to my company. We have experienced a 30 percent decline in our gross annual revenue since 2001, and we were unsure if we could continue on with this. We again raised our deductible from 1,000 a month to 2,500—excuse me—our deductible from $1,000 to $2,500, and we increased our prescription deductible from $200 to $400. This wasn't great for our employees but it brought the insurance coverage within a premium that we could handle. It was actually within $100 of where we had been. We felt comfortable with this, so we added a wellness benefit that my employees could go get annual checkups at no cost.

However, my employees who have dependents, we pay the insurance for our employees and the employees pay for their dependents, and those of us with dependents still saw an increase to our cost or a reduction in our checks.

When we started the firm we had $250 deductible and we had told the employees that we would keep it at that no matter where we changed it. But this year we were faced with such an increase that we could no longer feel comfortable picking up the slack for the increased deductible.

We changed to an HRA plan and we cover now $1,000 of their $2,500 deductible. We would really like to continue offering health insurance to our employees. We feel it is important to our company. We feel it is a nice benefit that the employees ought to have, and I do not know what the solution is.

I have talked to various businessmen. I have talked to my insurance agent. I have looked at health savings accounts. I have looked at PPOs. I have looked at just providing increased salary to my employees to see if they could get insurance coverage on their own cheaper than we can get it at a group rate. I just recently heard about the AHPs, and I am not very familiar with them.

What I do know is that in my State I have limited sources of insurance coverage. My agent tells me that we have three providers in the State, and I have been with all three of them now. I am not sure what my alternatives are.

What I need is affordable premiums with deductibles that are manageable for my employees.

Thanks for inviting me here today, Chairman Enzi, and thanks for your support of small business.

The CHAIRMAN. Thank you for your testimony.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF MITCHELL BLAKE

Good morning Mr. Chairman and members of the committee. Thank you for inviting me today to talk about the important issue of affordable, accessible health insurance, especially for those owning or working for small business. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing other small business members who face a similar challenge.

In April 1996, Tom Ward and I formed Ward + Blake Architects in Jackson, Wyoming. We employ eight people at present, and our firm designs residential and commercial buildings. We are pleased that our work has been recognized in notable national building publications, and our firm has won several local and regional American Institute of Architect's awards. Chairman Enzi, you may be familiar with Spring Creek Ranch Resort in Jackson, Wyoming or the Nature Conservancy at Red Canyon Ranch in Lander, Wyoming. Our firm designed both of these facilities.

One of our goals is to create a relaxed environment where the powers of creativity can flourish. We feel strongly that offering our employees good benefits is an integral part of having this environment.

I'm here today to share with you the growing problem that my firm is experiencing offering health insurance to our eight employees. We offer health insurance to all eight, and all of them take advantage of it. We offer health insurance for a variety of reasons: it's the right thing to do, and it's a way to attract and retain employees. We feel it is important to remove stresses that our employees may face in their life, if at all possible, so that they can focus on our projects and perform their best work. Offering health insurance is one way that we're able to help relieve stress and create a positive work environment for our employees.

But I have to be honest that it's not getting any easier. Our story is one of increasing deductibles and higher premiums. When our firm first started insurance costs were not so prohibitive. We started out with Blue Cross, when their policy cost too much, we shifted to Life Investors Insurance Company of America. At one point in 2000, with eight employees our monthly premium costs were $2,821. We ended up shifting to John Alden Life Insurance Company in December 2001 when Life Investors pulled out of the group health insurance arena in Wyoming, and we faced an additional $2,000 a month to stay with them during their withdrawal period.

We began having trouble at the end of 2002. In October of this year, one of our employees who had twin daughters found that one was not developing well, and it turned out that she had a malignant brain tumor. My employee was devastated with the news. We told him to take as much time as he needed to deal with the medical tests and specialists he was involved with in determining her condition. We paid him full salary for three months while he was in Salt Lake City at Primary Children's Hospital with his daughter. We then paid him full salary for three additional months while he came to work on a half-time basis so that he could be with his daughter and continue with follow-up meetings with the medical specialists.

When it came time for renewal in December 2003, John Alden increased their new renewal premium for nine employees from $2,075 a month to $3,220, or our plan would cost us an additional $13,740 on an annual basis. We amended the plan to increase the deductible from $500 to $1,000 and increased the out of pocket limit from $5,000 to $6,000 and a 50 percent copay in order to bring the premium down to $2,880 per month or about a $9,660 annual jump. We agreed on this working with our agent, Summit Insurance, who was working with John Alden, and sent a check on December 19, 2003. We would have paid earlier, but we were still working with our agent on a premium that we could afford and were told by our agent that if the premium was received before the end of the month that our policy would remain in effect.

On December 31, 2003 we sent in our January premium not knowing that we would be cancelled.

On January 6, 2004, we received notice that we had been cancelled even though our check had been deposited and cleared our bank.

Our insurance agent and the Wyoming Insurance Commission pressured John Alden into taking us back, but only as a new group. Due to the cancer issues, this made the amount significantly more than the renewal premium we had just agreed to accept. We declined this, stating that we were already an approved group and should not have to pay for a new group premium. We felt that we were treated unfairly by John Alden and requested that our premiums be returned. We were especially upset by the fact that John Alden had cashed our January premium even after they had sent us the letter of cancellation.

Because we had refused John Alden's new group renewal and requested our premiums back, we had to provide our employees with an insurance bridge plan until we could find a new carrier. In addition, we paid 100 percent of all outstanding

medical expenses that our employees had for the two months that they were technically uninsured.

Based on the advice of our insurance agent we removed my employee's daughter from our group insurance, once we found that she qualified for the Wyoming Health Insurance Plan (WHIP), being that she qualified as uninsurable, and we obtained a new carrier. All this time John Alden retained both of our premium checks.

We switched to Starmark Insurance in April 2004. Our initial monthly premium was $2,350 for eight employees with a $1,000 deductible, 60 percent copay, $5,000 out of pocket. This year Starmark wanted to renew our policy at $3,177 or about an $823 increase in monthly premiums, close to $10,000 annually. So we've now switched to an HRA account, with a monthly premium of $2,510, a $2,500 deductible for singles and a $5,000 deductible for families and increased our prescription deductible from $200 to $400. This adjusted our monthly premiums to within $100 of our 2004 premiums, so we added a wellness benefit to the plan so that our employees could get an annual physical at no cost to them. It is important to know that even though the cost to my company was within $100 of the previous years premiums, my employees with dependents saw an increase in their dependents' premiums for which they are responsible.

When we started this business, we only asked our employees to pay $250 toward the cost of their health insurance because that was the amount of the deductible from our first health insurance plan. We kept it at $250 even when the deductibles increased and as the monthly premiums increased, but we have had our gross annual profits reduced by 30 percent since 2001 and just cannot afford to do that anymore and still offer health insurance. With our new HRA plan, we now cover $1,000 of the deductible and ask our employees to pay $1,500.

As I said at the beginning, we want the best for our employees because it's the right thing to do and creates a positive, healthy work environment. But increasing health costs call into question how long we'll be able to offer this benefit without eliminating other benefits and still stay in business.

I'm not sure what the solution is: I have discussed the issue with several other business owners and looked at alternative ways to provide health insurance for my company including Health Savings Accounts, PPO's, and even increasing salaries so that employees can get their own individual policies. I realize that the hearing today is looking at association health plans. I am not totally familiar with AHP advantages, but I do know that I am limited to three health insurance providers in Wyoming and therefore have limited options for my employees. I also know that something must be done to stop this ever-increasing cost to small business. I want what's going to lower my premiums and enable me to continue offering health insurance. I want health insurance that makes my employees feel secure and at deductibles that are manageable.

Thanks for inviting me here today, and Chairman Enzi, thanks for your support of small business.

The CHAIRMAN. Mr. Rossmann?

Mr. ROSSMAN. Mr. Chairman, members of the Senate Health, Education, Labor, and Pensions Committee, thank you for holding this hearing to address the problems that small business face in providing quality health insurance for themselves and their employees.

I am testifying here before you today on behalf of the Association Health Plan Coalition, which consists of over 150 regional and national organizations. The AHP Coalition represents over 12 million employers and 80 million small business workers throughout the United States.

I am excited about this AHP legislation in S. 406 because I know that it is a model that works for small employers. Association Health Plans are an important option that brings more competition back into the marketplace. It goes without saying that small employers have their backs against the wall, struggling to maintain a business and at the same time being able to provide quality health insurance coverage to their employees and families.

The problem is exacerbated because they must mitigate the effects of the annual double-digit health insurance rate increases that have hit them over the past 4 to 5 years.

At the same time we have seen major insurance companies consolidating for what they call increased efficiencies and economies of scale, telling us that bigger insurance companies would have more clout to negotiate lower prices from hospitals, doctors and drug companies. According to an article written in the Washington Post in January 2005 this just has not happened. Instead our reward seems to be the creation of local and national oligopolies characterized by less competition, less choice, higher prices and higher returns to insurance company stockholders.

The Post went on to report that James Robinson, a Professor of Health Economics calculates that the top three health insurance companies control two-thirds or more of the business in all but 14 States, with numbers reaching as high as 92 percent in Maryland and 98 percent in DC and Northern Virginia. Robinson juxtaposes those numbers with the 2000 to 2003 financial results of the top five national firms, and he shows a decline in the percent of each premium dollar that goes to pay medical costs, along with a stronger trend toward higher premiums, higher profits and stock prices.

This appears to have been accomplished on the backs of small employers who have borne the brunt of double-digit rate increases over the past 5 years.

The bottom line to me seems to be that we need to create more competition in the health insurance marketplace and provide more options for small employers, not fewer.

I have been involved with Associated Builders and Contractors Association Health Plan for over 17 years. During that time I have been the Vice President of Fringe Benefits for ABC. I have worked for trade associations exclusively in their health insurance programs for almost 28 years. I can tell you from experience that association health plans work for small employers.

Associated Builders and Contractors started its health insurance trust back in 1957 by five contractors who were just too small and could not buy health insurance coverage on their own. Since 1957 we have enjoyed a 48-year history of providing health and other welfare benefits to contractor members and their employees throughout the United States. During the first 43 years ABC's insurance trust had only two different insurance carriers for the plan. This speaks very highly of the stability of the program and also the confidence that the insurance companies placed in ABC and in our plan.

ABC is also a perfect example of the savings that are available to small employers through an AHP. The total cost for the ABC health program varied from 13½ cents on the dollar to 16 percent, and that included all insurance company expenses. The administration, sales expense and profits of insurance carriers selling in the small group market by some of the largest providers is targeted at 35 percent. The difference between their number and ABC's number is 19 to 22½ percent in savings, which goes directly to the small employer this year and in future years.

In 1999 ABC's insurance carrier came to us and told us that they no longer wanted to stay in the business of providing association

group insurance plans under the master insurance trust concept. They did not want to because of the complexity and inconsistency of State laws. That statement was very understandable to me because in the 5 to 6 years before that we saw our association program being carved to pieces as our insurance carrier pulled out of one State after another because of the State small group insurance legislation activity. It became almost impossible for them to comply with the new State laws and to provide the master trust policy approach for ABC's trust.

ABC had a strong viable program which was gradually dismantled piece by piece by well-intentioned State insurance reform. We talked to over 50 different insurance carriers to take over ABC's insurance trust, which at that point was about $44 million in business, and there were no takers. No insurance company wanted to be involved with the association master trust program with the State healthcare reform requirements as they exist today. They are just too inconsistent and piecemeal.

In 1999 ABC even looked at the idea of going self-insured, but we determined that the expense involved in complying with each and every State's separate filing requirements would have cost more in the long run than we could have saved for our members.

The AHP story is like a poster child for AHPs. We provided an affordable comprehensive set of health insurance plans, but were eventually eliminated because of the changes at the State level. We succeeded as an AHP but were legislated out of serving our members. We want to pass the AHP legislation in S. 406 to bring this option back to our members because it fosters competition and it is a model that works, and it is also a model that does not have its hand out for Government subsidy.

I am very excited about association health plans and I appreciate this opportunity to testify before the committee on an issue of vital importance to our membership and all small business owners across the country. We look forward to continuing with a constructive dialogue on how to increase access to affordable health insurance for small employers.

I will be happy to answer any questions the committee may have. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Rossmann follows:]

PREPARED STATEMENT OF JOSEPH E. ROSSMANN

Introduction

Mr. Chairman, Ranking Member Kennedy and members of the Senate Health, Education, Labor, and Pensions Committee, thank you for holding this hearing which will address the problems that small businesses face in providing quality health insurance for themselves and their employees.

My name is Joseph E. Rossmann, and I am Vice President of Fringe Benefits for Associated Builders and Contractors (ABC). ABC is a national trade association representing over 23,000 general contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry in a network of 79 chapters. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With more than 80 percent of construction today performed by merit shop contractors, ABC is proud to be their voice.

I am testifying before you today on behalf of the Association Health Plan (AHP) Coalition (membership list attached), which consists of over 150 national and re-

gional organizations that support S. 406, the Small Business Health Fairness Act of 2005 sponsored by Senator Olympia Snowe (R-ME). The AHP Coalition represents over 12 million employers and over 80 million small business workers throughout America. I also am secretary and past president of The Association Healthcare Coalition, which consists of bona fide trade and professional associations that currently operate association-sponsored health plans, or have done so in the past. I will be summarizing my comments, but I would request that my full statement be submitted for the official record.

Mr. Chairman, today's hearing is extremely timely. The problem of small business workers not having access to affordable health benefits is reaching epidemic proportions across the Nation. Since over 60 percent of all uninsured Americans are employed by a small business, or are dependents thereof, the current trend of skyrocketing premium increases threatens to greatly expand the number of uninsured Americans, which now stands at approximately 45 million.

Indeed, massive premium increases of 30 percent, 40 percent and higher, and/or benefit reductions, are typical of what small businesses throughout the Nation are experiencing today. Clearly, current initiatives aimed at expanding access to affordable healthcare are not working. As such, Congress must take action to address this critical issue this year to prevent thousands of small business workers from losing their health benefits, and to expand coverage to millions of uninsured Americans.

Our coalition strongly urges Congress to enact the Small Business Health Fairness Act of 2005 (S. 406), bipartisan legislation which would bring much needed competition to the small group health insurance market. Congress should approve the AHP bill this year to expand access to health benefits for small businesses and the self-employed.

The Need for Association Health Plans

The Small Business Health Fairness Act of 2005 would help achieve the goal of providing Fortune 500-style health benefits to working families employed by small businesses. Through this legislation, AHPs will empower our Nation's entrepreneurs with the same tools that large employers and unions currently enjoy under the Employee Retirement Income Security Act (ERISA) making health coverage affordable for working families. These tools are:

- Economies of scale and increased bargaining power for small employers;
- Administrative savings from having one uniform set of rules;
- The option of self-funding health benefits;
- Health benefit design flexibility;
- Increased competition in health insurance markets.

AHPs can reduce health insurance costs by 15–20 percent by allowing small businesses to join together nationwide to obtain the same economies of scale, bargaining clout, and administrative efficiencies now available to employees in large employer and union health plans. New coverage options will promote greater competition and more choices in health insurance markets. In order to make sure benefits for small business workers are secure, the legislation also contains tough solvency standards.

The Small Business Health Fairness Act is the **only** proposal before Congress which will put small business workers on a level playing field with employees in large corporations or union health plans. Right now, small business workers are second-class citizens when it comes to health benefits. On average, workers in firms with less than 10 employees pay 17 percent more for a given health benefit than workers employed in a large company. This is because small businesses don't have access to the type of economies of scale, bargaining power and administrative savings that corporate and union plans now have. The AHP legislation will help rectify this inequity by leveling the playing field between workers in small and large businesses.

We estimate that AHPs, through the enactment of S. 406, can reduce the cost of health benefits by 15–20 percent for small business workers. We know this because association plans have already proven they can deliver savings compared with the cost of small employers purchasing directly from an insurance company. For example, the AHP sponsored by ABC for nearly 45 years, which operated nationally, had total administrative expenses of 13½ cents (13.5 percent) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim payment expenses and State premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 25 to 35 cents (25–35 percent) for every dollar of premium. **Moreover, any profit generated by an AHP in a given year does not go to the stockholders of the insurance company, but rather stays in the plan and inures to the benefit of participants by keeping costs lower in the future**.

ABC successfully operated an Association Health Plan through the ABC Insurance Trust. Because of the overwhelming costs in trying to comply with overlapping, inconsistent and often incompatible State laws, our health insurance carrier was forced to drop their AHP coverage. Today, ABC continues to provide a full array of insurance benefits, but has been forced to work with multiple health insurance providers. ABC now serves as a broker, providing our membership with the most competitive carriers and rates in their area. ABC is a perfect example of how a trade or professional association, serving as a purchasing pool for employers, can have a significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not afford group health insurance for their employees in the open market due to their size. Until 1999, the ABC Insurance Trust served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success was that it was guided by contractor members who serve as trustees and fiduciaries under the plan. As participants in the program, they acted in the best interest of their fellow members and their employees. Participation by the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's Association Health Plan program offered HMOs, PPOs, and traditional health insurance plans. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. ABC continues to offer dental coverage, group life insurance, and disability programs to serve members of the association. A majority of those covered work for small construction firms with 10–20 employees.

ABC's Insurance Trust operates in full compliance with ERISA reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Complying with the Federal HIPAA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, Association Health Plans are specifically referenced and defined in the HIPAA legislation and are required to take all members under HIPAA guidelines.

The inability of States to provide a regulatory environment in which associations can serve as a source of affordable health benefits for small business workers is a real tragedy. Bona fide trade associations have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationships. This unique structure allows associations to add value to their members and workers that other organizations or purchasing pools cannot duplicate. AHPs are capable of offering valuable options by providing additional benefits over and above what many insurance companies provide today. Associations can successfully tailor the products and services specifically for the needs of their members.

Workers in small businesses desperately need a viable mechanism to band together to increase their bargaining clout and create more competition in health insurance markets. This is true more so today than ever before due to the huge wave of consolidation among health insurance companies and hospitals. Recent mergers of health insurance companies have reduced competition and alternatives for small employers who seek access to quality and affordable health insurance. In fact, a survey of State insurance commissioners conducted by the General Accounting Office (GAO) at the request of Senator Kit Bond (R-MO) found disturbing levels of concentration on the small group health insurance markets, with market shares of nearly 90 percent among the five largest companies in 7 States.

Dr. James Robinson, Professor of Health Economics at the University of California, Berkeley, calculates that the top three health insurance companies control two-thirds or more of the healthcare business in all but 14 States. (Robinson, James C., *Consolidation and the Transformation of Competition in Health Insurance*, Health Affairs, Vol. 23, No. 6 (Nov. /Dec. 2004)). Robinson compares those numbers with 2000–2003 financial results of the top five national insurance firms. His research shows a decline in the percent of each premium dollar that goes to pay medical claims, while insurance companies have enjoyed double digit growth in premiums, earnings and equity share prices. Ultimately, Robinson contends that the health insurance industry will only be revitalized through product innovation and further competition.

Today, there is a great need to bring more competition back into the system rather than continually reducing it. By providing more options and choices for small employers, the AHP legislation will inject greater competition in health insurance markets, thus bringing down premiums and expanding health plan benefits and plan options to more small business workers and their families.

Rebuttal of Criticism of AHP Legislation

I would like to address some of the criticisms of S. 406 that have been raised by large insurance companies and State insurance commissioners, who have a vested interested in maintaining the status quo. First, opponents claim that AHPs will "cherry pick" the market and only benefit healthier groups of people. But the assumptions under which this argument is made do not hold up to scrutiny.

AHP legislation will **not** result in cherry picking for the following reasons:

- The Small Business Health Fairness Act of 2005 explicitly prohibits association health plans from AHPs from denying coverage to any eligible participants based on the health status of an individual employer or employee. Thus, it will not be possible for AHPs to "cherry pick" because sick or high risk groups or individuals cannot be denied coverage;
- The bill contains strict requirements under which only **bona fide** professional and trade associations can sponsor an AHP. These organizations must be established for purposes **other than** providing health insurance for at least 3 years. Thus, an AHP **cannot** "select a population that is healthier than those in other regulated pools." The bill strictly prohibits "sham association plans" set up by insurance companies in the past as a front group aimed at cherry picking the market;
- Opponents' allegations about adverse selection rest on the **mistaken assumption** that small businesses will offer only "bare bones" benefit packages through AHPs. There is broad agreement that "bare bones" plans, wherever they have been tried, have failed due to lack of demand. This is because small business workers want Fortune-500 style benefits like those enjoyed by workers in large companies. Also, small businesses must offer benefit options comparable to those offered by large companies if they are going to attract and retain quality employees;
- Adverse selection that **currently exists** in State markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable;
- The bill gives small businesses the ability to offer the **same** type of benefit packages now available to health plans established by large corporations and labor unions;
- Non-profit associations exist to serve their members. If they attempt to exclude members to avoid higher risks, or do not offer attractive benefit options, their mission is fundamentally compromised and they will not be able to compete in the marketplace;

The other major criticism of AHP made by opponents of this legislation is that benefits offered by AHPs will not be secure. This ignores two facts: First that AHPs under this legislation are fundamentally different from MEWA health plans which operate under Federal and State laws; and second, it ignores the strong solvency standards required for AHPs under the bill, which will increase consumer protections for many small business workers. The bill requires the following solvency provisions for self-funded AHPs:

- Claims reserves certified by a qualified actuary;
- Minimum surplus requirements;
- Both specific and aggregate stop-loss insurance;
- Indemnification insurance to ensure that all claims are paid;
- AHPs must register with the State in which they are domiciled;
- AHPs must abide by strict disclosure and actuarial reporting procedures; and
- The bill provides severe criminal and civil penalties to combat fraud.

Indeed, a former Inspector General at the Department of Labor has testified before Congress that the new enforcement tools for regulators contained in this legislation will help reduce health insurance fraud. Thus, allegations that health coverage obtained through AHPs will not be secure ignore these strong protections contained in the bill.

Conclusion

In conclusion, the 12 million employers and more than 80 million employees represented by the AHP Coalition strongly urge Congress to pass, and the President to sign the Small Business Health Fairness Act of 2005 into law. Association Health Plans provide affordable health coverage to small businesses, and extend coverage to uninsured people. While AHPs are not the only solution to America's healthcare crisis, AHPs are an essential component of the solution. AHPs are important for many working families employed in small businesses who otherwise could not afford coverage. Passage of the Small Business Health Fairness Act of 2005 will ensure that employees of small businesses receive the affordable, high quality healthcare coverage they both need and deserve.

I appreciate this opportunity to testify before this committee on an issue of vital importance to our membership and small business owners across the country. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses. I would be happy to answer any of the questions the committee may have.

ORGANIZATIONS SUPPORTING ASSOCIATION HEALTH PLANS

The following organizations, representing over **12 million employers and 80 million workers, strongly support S. 406 and H.R. 525, the Small Business Health Fairness Act of 2005**, bipartisan legislation to strengthen and expand Association Health Plans (AHPs). This legislation will provide workers employed in small businesses and the self-employed gain access to Fortune 500-style health benefits now enjoyed by workers in corporate and labor union health plans.

Adhesive and Sealant Council, Air Conditioning Contractors of America, American Alliance of Service Providers, American Apparel & Footwear Association, American Association of Advertising Agencies, American Association of Engineering Societies, American Association of Franchisees and Dealers, American Association of Small Property Owners, ABL—America's Wine, Beer, and Spirit Retailers, American Bakers Association, American Concrete Pumping Association, American Council of Engineering Companies, American Disc Jockey Association, American Electronics Association, American Foundry Society, American Furniture Manufactures Association, American Institute of Chemical Engineers, American International Automobile Dealers Association, American Hotel and Lodging Association, American Lighting Association, American Nursery and Landscape Association, American Rental Association, American Road and Transportation Builders Association, American Small Businesses Association, American Society of Association Executives, American Society of Civil Engineers, American Society of Home Inspectors, American Society of Mechanical Engineers, Board on Member Interests & Development, American Staffing Association, American Textile Machinery Association, American Veterinary Medical Association, American Wholesale Marketers Association, Americans for Tax Reform, AOMALLIANCE, Archery Trade Association, Associated Builders and Contractors, Associated General Contractors of America, Associated Prevailing Wage Contractors, Inc., Association for Manufacturing Technology, Association of California Water Agencies, Association of Equipment Manufacturers, Association of Independent Maryland Schools, Association of Ship Brokers and Agents, Association of Suppliers to the Paper Industry, Automotive Aftermarket Industry Association, Automotive Aftermarket Association Southeast, Automotive Service Association, Automotive Undercar Trade Organization, Automotive Wholesalers Association of New England, Automotive Parts & Services Association, Bowling Proprietors' Association of America, California Motor Car Dealers Association, California Society of CPAs, California/Nevada Automotive Wholesalers Association, Center for New Black Leadership, Central Service Association, Chesapeake Automotive Business Association, Cleveland Automobile Dealers Association, Club Managers Association of America, Christian Schools International, Coca Cola Bottlers Association, Communicating for Agriculture, Construction Management Association of America, Consumer Specialty Products Association, Deep South Equipment Dealers Association, Electronics Representatives Association, Insurance Trust, Far West Equipment Dealers Association, Farm Equipment Manufacturers Association, Financial Executives International, Financial Planning Association, Food Marketing Institute, GrassRoots Impact, Hearth, Patio and Barbecue Association, Hispanic Business Roundtable, Independent Electrical Contractors, Independent Office Products & Furniture Dealers Association, Independent Stationers, Inc., Institute of Electrical and Electronics Engineers—United States of America, International Association of Professional Event Photographers, International Foodservice Distributors Association, International Franchise Association, International Housewares Association, Iowa Automobile Dealers Association, Iowa-Nebraska Equipment Dealers Association, The Latino Coalition, Mason Contractors Association, Material Handling Equipment Distributors Association (MHEDA), Metal Manufacturers' Education and Training Alliance, Midwest Automotive Industry Association Midwest Equipment Dealers Association, Motor & Equipment Manufacturers Association, NAMM, the International Music Products Association, National Association for the Self-Employed, National Association of Chemical Distributors, National Association of Community Health Centers, National Association of Computer Consultant Businesses, National Association of Convenience Stores, National Association of Home Builders, National Association of Manufacturers, National Association of Plumbing-Heating-Cooling Contractors, National Association of Realtors, National Association of Theatre Owners, National Association of Wholesaler-Distributors, National Association

of Women Business Owners, National Automobile Dealers Association, National Black Chamber of Commerce, National Burglar and Fire Alarm Association, National Cattlemen's Beef Association, National Club Association, National Concrete Masonry Association, National Council of Agricultural Employers, National Federation of Independent Business, National Franchise Association, National Funeral Directors Association, National Lumber and Building Material Dealers Association, National Newspaper Association, National Office Products Alliance, National Paint and Coatings Association, National Portable Storage Association, National Precast Concrete Association, National Rental Association, National Retail Federation, National Restaurant Association, National Roofing Contractors Association, National Spa and Pool Institute, National Society of Accountants, National Society of Professional Engineers, National Sporting Goods Association, National Systems Contractors Association, National Tile Contractors Association, National Tooling & Machining Association, National Utility Contractors Association, Nebraska New Car and Truck Dealers Association, New Mexico Automotive Parts and Service Association, New York State Automotive Aftermarket Association, North American Die Casting Association, North American Equipment Dealers Association, North American Retail Dealers Association, North Dakota Automobile and Implement Dealers Association, Northeastern Retail Lumber Association, Office Furniture Dealers Alliance, Ohio Valley Automotive Aftermarket Association, Outdoor Industry Association, Piano Technicians Guild, Precision Machine Products Association, Precision Metalforming Association, Printing Industries of America, Printing Industries of Maryland, Process Equipment Manufacturers' Association, Professional Detailing Technicians Association, Professional Golfers' Association of America, Professional Photographers of America, Retailers Bakery Association, Service Station Dealers of America and Allied Trades, Self Insurance Institute of America, Small Business Survival Committee, Society of American Florists, Society of the Plastics Industry, Society of Professional Benefit Administrators, Southern Equipment Dealers Association, Southeastern Equipment Dealers Association, Southeastern Farm Equipment Dealers Association, Southwestern Association, Specialty Equipment Market Association (SEMA), Snack Food Association, Student Photographic Society, Textile Rental Services Association of America, The Association Healthcare Coalition, Timber Operators Council Management Services, Timber Products Manufacturers Association, Tire Industry Association, United States Federation of Small Businesses, Inc., U.S. Chamber of Commerce, U.S. Hispanic Chamber of Commerce, U.S. Pan Asian America Chamber of Commerce, Vermont Automobile Dealers Association, Virginia Bankers Association, Washington Area New Automobile Dealers Association, Western Growers Association, Women Impacting Public Policy, Wisconsin Automobile & Truck Dealers Association, World Wide Insurance Services, Inc.

The CHAIRMAN. Ms. Ignagni?

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the committee. It is a pleasure to be here this morning and a pleasure to be part of this distinguished panel.

The subject of this hearing is to improve access to healthcare, affordable access for small business. We understand the committee is trying to assemble a menu of strategies that will expand access, reduce costs, and what we have tried to do in our testimony today is first discuss the many dimensions of the cost problem. The best way to make this point is to use the balloon analogy. As you press down on one side the other gets larger. What we have tried to do is give you a menu of strategies that will shrink the balloon.

Essentially there are six problems. They are distinct, but they are all interrelated. First we have price increases in healthcare. We provided very strong data that suggests that we did a very good job in the 1990s bringing down healthcare costs, bringing 5 million employees into the system that heretofore did not have it. We had a discussion about those tools and techniques under the heading of Patient Protection. We were asked by the Members of the Congress, individuals in the State legislature, to pull back on some of those tools. We did pull back, and not surprisingly, costs grew, making it more difficult for small business to come back into the system or to maintain access in the system.

We have now, over the last several years, reinvented tools and techniques which I am going to be talking about and which our testimony highlights, and we are seeing some tangible results which we are positive about, which we think begins to shrink that balloon and to deal with those acute problems talked about by my colleagues.

In addition to the price side, Mr. Chairman and members of the committee, there is also a quality issue. 50 percent approximately, only 50 percent of what is done today, according to the Rand Corporation, is classified as best practice, which means there is confusion and differences of opinion and lack of information about how best to meet patients' needs. We have high cost treatments. It used to be we were talking about hundreds of dollars. Now we are talking about thousands and potentially hundreds of thousands of dollars with respect to new devices, biologics, etc.

We have cost shifting when we have a problem at the State level, particularly with Medicaid, when Government pays less. That means private employers pay more.

We have a malpractice problem. $100 billion associated with defensive medicine, that could be reoriented toward helping small business.

Transparency, consumers have information about health plans but almost no information about the care that is delivered by doctors and hospitals.

In our testimony we have tried to give summary of where we are getting results in terms of pharmaceutical expenditures decreasing, care coordination, disease management, aligning payment with quality performance to improve the efficiency and effectiveness of the system.

We have also provided information on SHAs. The Congress, 16 months ago as part of the Medicare Modernization Act, authorized HSAs. We reported that 1 month after the regulations had been implemented 438,000 people were in HSAs. We are about to report new numbers. They will be reported in the next 2 weeks. We are going to be showing a number of over a million, so we are seeing a growth in that arena.

I would also like the committee to know that in the previous study in September we saw roughly a third of individuals purchasing HSAs had not had health insurance. That number is now up a little more. It is a little less than 40 percent, and we will be reporting those data in about 2 weeks.

We think also there are things that Government can do. We have talked about tax credits, particularly for low-wage workers and small business. We have talked about State high-risk pools. This committee has passed important legislation, and we hope the Senate passes it and the Congress enacts it at the State level. We have talked about the importance of regulatory harmonization and uniformity. That the single fastest increase in premium cost is in the area of compliance cost. We have a confusing patchwork quilt all around the country.

We have been working with Commissioner Praeger and her colleagues at the NAIC and your colleagues here in the Senate and the House to try to get movement going toward regulatory harmonization. We have talked about medical liability reform. We have

talked about tech assistance and effectiveness analysis. We need to begin to think about strategies, public/private strategies to move on that, and we have talked about encouraging transparency.

Finally, we have also commented on AHPs. In our view it is an invitation for adverse selection. We are concerned about the potential, the strong evidence to suggest that—with all due respect to the goals of the individuals that have proposed this strategy and to my colleagues' observations, we understand that folks are desperately trying to solve the problems of small business and we are very sympathetic, but in our view it will exacerbate the problems in the name of potentially helping only a few. The Congressional Budget Office has indicated that we would see that 80 percent of individuals and small business would have an increase. The Academy of Actuaries has raised concerns about the effectiveness and the stability of those funds, and we are hoping that those will be issues and data that the committee takes into consideration.

So, Mr. Chairman, we want to work in partnership with the committee. We want to provide solutions. We want to provide answers and we want to help you sort through these very difficult problems so we can shrink that balloon.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI

Good morning, Mr. Chairman and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We would like to commend the committee for looking broadly at a wide range of options for meeting the healthcare needs of small employers and their employees. By widening the scope of this debate, you are opening the door to considering a comprehensive set of solutions that could improve choices for small businesses and help bring costs under control for all Americans. Our members are committed to working closely with you to identify workable strategies and to support your efforts.

My testimony today will focus on four issues:

- The challenge of confronting rising healthcare costs;
- A description of what health insurance plans are doing to control health costs, enhance choices, and improve quality;
- Recommendations for increasing the availability of affordable healthcare options; and
- An analysis of the potential unintended consequences associated with one of the options, association health plans (AHPs), that has been proposed to make health coverage more affordable for small businesses.

THE CHALLENGE OF CONFRONTING RISING HEALTH CARE COSTS

The committee is starting its work in the right place—by focusing on rising costs and the affordability of coverage—because when healthcare costs outpace growth in the overall economy, businesses large and small find it more difficult to provide or maintain coverage. While we are encouraged about what we can do in the private sector to continue to reduce growth in healthcare spending, we believe that all stakeholders—including the government—have a role to play in working together to accomplish this objective. Evidence also strongly suggests that attention needs to be drawn to the efficiency and effectiveness of healthcare services if purchasers are to be assured that they are receiving maximum value for their healthcare investment.

From 1994 through 1999, national health expenditures were in line with overall economic growth, because health insurance plans implemented a variety of tools to keep costs under control. This had a direct impact on the ability of employers to

purchase affordable coverage for their employees. Indeed, the Lewin Group estimated that up to 5 million people [1] who otherwise would have been uninsured were able to receive coverage as a result of these costs being restrained.

As the policy debate shifted away from containing costs, legislative proposals at both the Federal and State levels focused on rolling back the mechanisms that were keeping healthcare affordable. This led to a new cycle of accelerating healthcare costs that has had an impact on all purchasers, particularly small businesses. Recognizing this challenge, our members have developed a new generation of cost containment tools that already are having a positive impact and showing promise for the future. For example, the rates of increase in pharmaceutical expenditures have significantly declined as a result of our members' implementation of programs to encourage greater use of generic drugs and other measures that encourage case management of chronic conditions. This progress is reflected in the most recent data from the Department of Health and Human Services (HHS), which projects that national healthcare spending increased by an estimated 7.5 percent in 2004—the lowest rate of increase since 2000. At the same time, healthcare costs still are growing faster than the overall economy.

The Center for Studying Health System Change has noted that hospital prices continue to be a major factor behind increased spending, accounting for almost half of the annual rate of increase in healthcare expenditures. At the same time, innovative drugs, devices and other therapies—while they can provide undeniable benefits in life expectancy and improved quality of life—are significant cost drivers. Without any organized way to assess the impact of this technology or compare the effectiveness of various therapies, employers and their employees are absorbing these higher costs without information about what works and the conditions under which certain therapies are effective. As the committee begins its work on the best methods to ensure post-marketing surveillance, we look forward to providing recommendations for your consideration. In addition, we support the efforts of Dr. Mark McClellan, administrator of the Centers for Medicare & Medicaid Services (CMS), who is working with the Institute of Medicine (IOM) to develop the information necessary to establish evidence-based coverage policies for Medicare. This effort will mark an important and needed transition.

As purchasers assess the impact of rising costs, they also are questioning whether they are getting the best value for their healthcare investment. Considering the Rand Corporation's finding that patients receive care in accordance with best practices only 55 percent of the time, more information about clinical effectiveness studies needs to be made available to physicians and other healthcare practitioners. As the committee reviews the work of the National Institutes of Health (NIH), we are prepared to offer recommendations for ensuring that information generated by this country's robust system of clinical trials is more quickly translated into everyday medical practice.

Cost shifting is another issue with significant implications for healthcare purchasers. The costs associated with uncompensated care—along with funding shortfalls in government health programs—are major causes of cost shifting. This translates into higher costs for private sector payers, including small employers, and underscores the importance of ensuring adequate funding for Medicaid and other government health programs.

On the regulatory side, the existing patchwork quilt of regulations frequently prevents employers from designing benefit packages that they can afford and, as a result, sometimes forces them to make the decision not to provide healthcare benefits. We have been working with the National Association of Insurance Commissioners (NAIC), your colleagues in the Senate Banking, Housing and Urban Affairs Committee, and the House Financial Services Committee to assess the impact of the lack of uniformity in regulation, the administrative burdens associated with exploding compliance costs, and recommendations for improvement.

Similarly, the country is not well served by the current medical liability system. This system creates incentives for excessive litigation—thereby delaying the resolution of disputes, fostering a culture of blame, and forcing doctors to practice "defensive medicine" that diverts up to $100 billion annually and fails to reduce medical mistakes. Patients deserve an improved system that promotes quality; resolves disputes in a fair, fast and effective manner; and lifts the burden of defensive medicine from healthcare providers.

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[1] The Lewin Group LLC, Managed Care Savings for Employers and Households: 1990 through 2000; 1997.

PRIVATE SECTOR COST CONTAINMENT AND QUALITY IMPROVEMENT INITIATIVES

In response to the latest cycle of rising healthcare spending, health insurance plans have been working aggressively to improve quality and control costs, while also meeting consumer demands for choice, through a variety of innovative strategies and initiatives.

Pharmacy Benefit Management

Health insurance plans use a wide range of pharmacy benefit management tools and techniques to reduce out-of-pocket costs for members and improve quality by reducing medication errors. These tools and techniques include:

- programs that encourage the use of generic drugs;
- step therapy programs that promote proven drug therapies before moving to newer, different treatments that are not necessarily better;
- negotiated discounts with pharmacies that participate in a plan's network;
- disease management techniques that include practice guidelines to encourage the use of the most appropriate medications; and
- appropriate use of mail-service pharmacies.

The success of these strategies is clearly evidenced by new data, released in December 2004 by the Center for Studying Health System Change, showing that growth in prescription drug spending has dropped from almost 20 percent in the second half of 1999 to 8.8 percent in the first half of 2004. A number of studies have reinforced that these tools and techniques are controlling costs in public programs:

- A 2003 study, conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania—the largest State pharmacy assistance program in the Nation—could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.
- Another 2003 study, conducted by the Lewin Group for the Center for Health Care Strategies, found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level States would otherwise have experienced under Medicaid fee-for-service programs. Plans achieved these savings by performing drug utilization review, establishing pharmacy networks, and encouraging patients to take the most appropriate medications.
- The Government Accountability Office (GAO) reported in January 2003 that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average price customers would pay at retail pharmacies.

Our members also are taking steps to improve patient safety and reduce the risk of medication errors. Health insurance plans have created pharmacy information systems which, as a matter of standard practice, alert pharmacists when the combination of two or more of a patient's medications could lead to an adverse drug reaction. Software that plans use in their pharmacy networks is programmed to identify hundreds of potentially harmful drug interactions, including those that could occur due to the patient's age or gender. When the system recognizes a dangerous combination of drugs or contraindications, an on-screen alert is sent to the pharmacist who can then call the patient's doctor to find a safer alternative.

Transitioning to Evidence-Based Medicine

Health insurance plans are working aggressively to promote evidence-based medicine. This term refers to the widespread adoption in everyday clinical practice of treatments and therapies that are consistent with the latest scientific evidence on what works best and reduces the number of inappropriate services that have little or no value to patient outcomes.

As part of this effort, our members are working with physician groups to increase the use of quality technology assessment and clinical practice guidelines that help clinicians make decisions about the most appropriate course of treatment for patients with a specific disease or symptoms. Furthermore, AHIP has collaborated with the Agency for Healthcare Research and Quality (AHRQ) and the American Medical Association to establish a National Guideline Clearinghouse—www.guideline.gov—which is a web-based resource that gives patients and providers access to the latest medical evidence on effective treatments and technologies. The National Guideline Clearinghouse provides access to both summaries and the full text of clinical practice guidelines, an electronic forum for exchanging information on best practices, and a tool that allows users to generate side-by-side comparisons for any combination of two or more guidelines.

Disease Management

Virtually all health insurance plans have implemented disease management programs to improve the coordination and quality of care for patients with diabetes, asthma, congestive heart failure, and other chronic diseases. These programs improve patient outcomes and satisfaction—and help control costs—by ensuring that these patients receive effective care on an ongoing basis so that they can avoid emergencies and unnecessary hospitalizations. A number of research studies have demonstrated that these programs are effective.

A study published in *Medical Care*[2] evaluated the impact of a heart disease management program on hospital service utilization, as well as the potential costs savings over and above the cost of delivering the program. This randomized controlled study included 443 women aged 60 or older with diagnosed cardiac disease who were seen by a physician approximately every 6 months. The results demonstrated that hospital cost savings exceeded program costs by a ratio of nearly 5 to 1. Moreover, program participants experienced 46 percent fewer inpatient days and 49 percent lower inpatient costs than the control group, while no significant differences between the two groups were reported in emergency room utilization.

Another study, published in the journal *Disease Management,*[3] examined the cost savings associated with a disease management program for three conditions (asthma, diabetes, and coronary artery disease). The preliminary results of this study show that the program produced a return on investment of $2.84 for each $1.00 invested.

Yet another study, published in *Managed Care,*[4] examined a large health management program for 120,000 individuals having, or being at high risk for, one or more of 17 chronic conditions or diseases. Findings for the first year indicate:

- a return of at least $2.90 for every dollar invested in the program;
- average overall savings of $41 per program member per month;
- 14 percent fewer hospital admissions;
- 18 percent fewer emergency room visits;
- significant improvement in diabetics' HbA1c levels; and
- absenteeism from work or school was reduced significantly (7–11 percent) among members participating in the program.

Health Information Technology

By implementing health information technology, our members are helping consumers make well-informed decisions about their healthcare, while also achieving greater efficiencies and cost savings throughout the healthcare system.

Health insurance plans have developed a wide range of health information technology initiatives, including secure Web sites that allow their members to quickly locate information about their benefits, check the status of claims, contact member services, or learn about preventive care, drug interactions, disease management, and other health issues. Other plans have created on-line pharmacies that allow enrollees to refill their prescriptions and access information about their medications. Another strategy implemented by a number of companies provides opportunities for members to receive health information from doctors and nurses through Web sites and e-mail.

Our members also are implementing information technology to improve claims processing, offer better customer service, decrease administrative costs, and enhance their overall efficiency. An October 2003 report by the GAO noted that health information technology allowed health insurance plans to reduce claims processing costs, improve the quality of claims data, improve staff productivity, and increase provider and customer satisfaction.[5]

The GAO study also noted that plans' implementation of health information technology has resulted in improved clinical care for members. For example, one plan reported that diabetic retinal exams increased from 71 percent to 93 percent and the rate of adolescents receiving a flu vaccination increased from 29 percent to 43 percent due to information technology that generated reminders for health screenings.

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[2] Wheeler, J. (2003). Can a disease self-management program reduce healthcare costs? The case of older women with heart disease. *Medical Care*. 41(6): 706–715.

[3] Cousins, M. & Liu, Y. (2003). Cost savings for a preferred provider organization population with multi-condition disease management: Evaluating program impact using predictive modeling with a control group. *Disease Management*. 6(4): 207–217.

[4] Gold, W. & Kongstvedt, P. (2003). How broadening DM's focus helped shrink one plan's costs. Managed Care Magazine. (accessed on November 2, 2004) www.managedcaremag.com.

[5] Information Technology Benefits Realized for Selected Health Care Functions." GAO October 2003.

AHIP and its members are committed to developing an interconnected healthcare system that improves personal health and the delivery of care, enhances healthcare quality, and increases productivity. We are committed to working with all stakeholders and the Office of the National Coordinator for Health Information Technology to develop uniform interoperability standards and business rules.

Redesigning Payment Models

Many health insurance plans are redesigning their payment models to reward healthcare providers for delivering high quality care. Paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine, thereby reducing unnecessary follow up care and improving efficiency—which in turn will lead to better health outcomes and greater value. This is a significant change in a system that historically has paid providers the same amount, regardless of the quality of care they deliver.

Under these new payment models, many health insurance plans are offering financial awards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing or a reduction in administrative requirements. Additionally, some plans are beginning to tier provider networks and offer consumers reduced co-payments, deductibles, and/or premiums for using providers deemed to be of higher quality (based on select performance measures).

Let me briefly highlight two examples of the innovative programs our members are implementing:

- One health insurance plan has developed a program that includes: (1) an online PPO physician report card that allows physicians to benchmark their performance compared to their peers; (2) a physician recognition program that provides rewards for superior performance on clinical, administrative and pharmacy indicators, and (3) information resources provided to the PPO physician network to support quality improvement.
- Another of our members has developed an initiative to improve enrollee health through improved access/timeliness of care, preventive screening, and adherence to evidence-based guidelines for the treatment of chronic conditions. Under this initiative, a physician advisory group helps to develop "performance targets" in key areas, such as patient satisfaction, emergency room utilization/access, access/office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma. Physicians then earn an award based on their level of performance: high, average and below average.

New Products: Bringing HSAs to Employers and Individuals

Besides using tools to promote quality and cost savings on an ongoing basis, health insurance plans are responding to the strong interest both employers and consumers have expressed in Health Savings Accounts (HSAs) as a new option for affordable health coverage.

This option allows beneficiaries to cover their healthcare expenses using a tax-free account in combination with a high-deductible health plan. Although this is a relatively new option that was authorized only 16 months ago by the Medicare Modernization Act of 2003 (MMA), more than 90 companies already offer high-deductible health plans that can be purchased in combination with HSAs. A wide variety of HSA products are available to consumers—including open access plans, preferred provider organizations (PPOs), and point-of-service (POS) plans. Health insurance plans that have contracts with providers can maximize the savings they deliver for employers and consumers.

Significantly, today's HSA products are more widely available and more popular than previous high-deductible options that Congress enacted in 1996. This is true for several reasons. First, the MMA allows any employer or individual to establish an HSA and make contributions to the account. Also, the product design for HSAs is much more flexible, particularly with respect to deductibles and out-of-pocket costs, and expenditures for preventive care and certain disease management services do not count toward an individual's deductible. Although HSAs were authorized by Congress at the Federal level, a number of States also have taken action to remove barriers to these new products.

Last year, an AHIP survey found that approximately 438,000 persons had established HSAs as of September 2004. This survey also indicated that among individuals who set up HSAs, 30 percent were previously uninsured and nearly half were over the age of 40. A more recent survey, which we will release soon, indicates that more than 1 million HSAs had been established as of March 2005. This reflects a more than two-fold increase in just 6 months. Additional findings from our survey

will shed light on this dramatic growth in HSA products and their potential for extending affordable coverage to more Americans.

AHIP and the Small Business Administration (SBA) have jointly developed a Web site—HSADecisions.org—to serve as a clearinghouse and educational resource for consumer information on HSAs. This site hosts an online Learning Center that features a library and glossary to help consumers and small businesses better understand available HSA options. HSADecisions.org also provides a list of insurers that offer high deductible health plans that can be purchased in combination with HSAs. The site is updated on a regular basis to ensure that consumers have access to the most recent and most accurate information.

RECOMMENDATIONS FOR EXPANDING THE AVAILABILITY OF AFFORDABLE HEALTH CARE OPTIONS

As the committee looks at cost drivers, assesses what can be done to improve the effectiveness of the healthcare system, and reviews private sector strategies that are being developed to reduce costs and improve quality, our members would like to offer eight principles for your consideration.

1. Modernize and Maximize the Effectiveness of the Regulatory System

• Encourage choice with uniform rules in the small group market: A common set of rules would encourage competition, enhance consumer choice, and provide greater predictability for employers. The solution is not to waive all requirements for particular groups, but to establish an appropriate and consistent framework for all participants to ensure that small employers have maximum options to meet their needs. This means that the Federal and State Governments need to work together to encourage "best practice" regulation. This process has begun with the development of draft legislation—known as the State Modernization and Regulatory Transparency (SMART) Act—that would promote uniformity in plan processes, particularly internal and external review of coverage disputes, speed-to-market and market conduct standards.

• Encourage prompt product approval and consistency in regulatory processes. Steps should be taken to ensure that States adopt a mechanism by which health insurance plans can bring innovative products to the market in a timely manner. Ideally, the Federal Government should encourage States to be forthcoming regarding their standards for policy rate and form filing requirements and to abandon unwritten "desk-drawer rules." This ultimately will create oversight mechanisms that allow companies to provide consumers with the products they need in a timely manner.

• Establish an independent advisory commission to evaluate the impact of mandates on healthcare costs and quality. Such a commission could advise policymakers on the safety and effectiveness of proposed and existing mandated health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

2. Pass S. 288, the "State High Risk Pool Funding Extension Act." AHIPs Board of Directors approved a statement in June 2004 indicating support for Federal funding for State high-risk pools to cover individuals who have unusually high healthcare costs. This legislation fits within the parameters of what Congress is able to accomplish from a budgetary standpoint at this time. We applaud the committee for taking action earlier this year to approve S. 288. This proposal is one of the next steps Congress should take as part of a long-term strategy for strengthening our Nation's healthcare safety net.

3. Expand Tax Credits to Encourage the Purchase of Health Care Coverage. To address the needs of working Americans who are uninsured and ineligible for public programs, Congress can help make health coverage more affordable by expanding tax credits for low-income persons. This approach will be particularly helpful to Americans who do not have access to employer-sponsored coverage and to those who decline such coverage because of the high cost. Moreover, tax credits could prompt more small businesses to offer employee health benefits. The Employee Benefits Research Institute (EBRI)[6] has reported that among small employers that do not offer employee health benefits, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

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[6] Employee Benefit Research Institute, *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*, January 2003.

4. Develop a Framework for Evaluating Technologies for Effectiveness and Efficiency. To address the rapid development of new procedures, devices and other technologies, a public-private framework should be established to evaluate and compare the effectiveness and efficiency of these technologies. Moreover, new post-marketing surveillance models should be developed to assess the appropriate use and long-term value of certain breakthrough drugs, devices and biologicals.

5. Invest in Cost Effectiveness Research. While the Federal Government invests heavily in clinical research, it makes only modest investments in research that compares the relative effectiveness of existing versus new therapies that are designed to treat the same condition. The Federal Government should assign a high priority to this kind of research and, furthermore, create a National Center for Effective Practices to ensure that the results are translated into usable information for providers and consumers.

6. Overhaul the Medical Liability System to Ensure Effective Dispute Resolution and Promote Safety and Value. The flaws in the current medical liability system should be addressed with reforms that place reasonable limits on healthcare litigation. Additionally, patient safety legislation is needed to establish legal protections for medical error information reported by healthcare providers, and to permit the aggregation of data that can be used to determine the causes of medical errors and develop strategies for improving patient safety. Also needed is a uniform, national administrative process to resolve malpractice disputes between patients and healthcare providers in a fair and efficient manner, thus avoiding the need for litigation as often as possible.

7. Encourage a Uniform Approach for Quality Measurement and Reporting. The Institute of Medicine (IOM) has made a strong case that patients need more information to make decisions about their healthcare treatment; physicians, hospitals and other healthcare professionals need more information to improve the quality of care they provide; and purchasers need more information to ensure that they are receiving value for their investment in healthcare benefits. Unfortunately, the existence of multiple and sometimes conflicting efforts to measure performance and report data on quality and efficiency is causing unintended consequences, including confusion among consumers, burdens on providers faced with uncoordinated data requests, and a diversion away from key priorities to improve quality. Leaders of the key healthcare stakeholder communities need to reach consensus about what should be measured, and how to make data aggregation and reporting effective and efficient. One uniform approach would be far more cost effective and would minimize the growing confusion associated with numerous measurement and data collection efforts. Critically, it also will help address the key issue that underlies the IOM's *Crossing the Quality Chasm* report—closing the gap between what the science indicates is best practice and what practitioners actually do.

8. Encourage the Development of an Interconnected Health Care System and Uniform Standards. The delivery of healthcare in America is complex with individuals seeking care from a variety of physicians, hospitals, and specialists. The ultimate goal of modernizing the healthcare system is to improve personal health and the delivery of care by providing meaningful personalized information to consumers and providers in a usable form and in a timely manner. To achieve this aim, we need uniform, national standards that enable the exchange of health information by and between clinical electronic health record (EHR) systems and consumer-centric individual health records.

UNINTENDED CONSEQUENCES OF ASSOCIATION HEALTH PLANS

AHIP and our member companies have grave concerns about legislation, S. 406, that would establish special rules and exemptions for national and regional association health plans (AHPs). We strongly support the goal of developing affordable healthcare options for small businesses. This legislation, however, would not achieve this goal and, in fact, would further drive up healthcare costs and leave more Americans uninsured.

I would like to preface my comments on this issue by highlighting a number of "myths" about AHP legislation and then outlining the "reality" of how this legislation would harm small employers. I also will discuss a specific example of how the proposed AHP legislation would likely result in higher premiums for a typical employer.

Myth: AHPs would reduce health premium costs for most small businesses.

Reality: In fact, the Congressional Budget Office (CBO)[7] has reported that AHPs would make health insurance less affordable for the vast majority of small businesses. According to CBO's analysis, 82 percent of small business employees would pay higher premiums under AHPs. This expected outcome is closely related to the fact that the proposed AHPs could set up headquarters in a State without laws that limit how much premiums can vary for small businesses based on differences in employee health status. AHPs also could choose to operate under Federal rules that do not have these rate limits.

Myth: AHPs would cover all populations equally.
Reality: Because AHPs could operate in the choice of environment most favorable to their bottom line, "cherry picking" of only the healthiest individuals would result. Although AHPs could not legally discriminate based upon health status, the absence of limitations on premium variations would ensure that quotes for small employers with a workforce in less than perfect health would be many times higher than for healthy groups. As a result, employers whose employees had incurred significant healthcare costs would be forced outside of the AHP. As soon as one or more employees of a small business experienced a serious illness, AHPs could drive up the group's rates and thus drive them out of the AHP. Ultimately, most small employers would be forced out of AHPs.

Myth: AHPs would reduce the cost of administering health benefits.
Reality: Each AHP would administer claims for its members. However, AHPs would need to recoup their administrative expenses by charging membership dues or by building administrative costs into the premiums. While some nominal savings potentially could be achieved on administration, in fact, small businesses most likely would end up paying the same or even more for administration of health benefits through AHPs.

Myth: AHPs will operate under strong oversight.
Reality: The legislation substitutes actuarial oversight with a self-policing actuarial certification and State solvency standard with a limited $2 million reserve. According to the GAO and the Department of Labor, staffing resources are completely inadequate to meet the challenge of the added regulatory responsibility. In addition, the American Academy of Actuaries concluded that the capital standards are inadequate for any AHP larger than 5,000 insured.

Myth: AHPs would be better positioned to negotiate discounts with doctors and hospitals.
Reality: Health insurance plans operating in the small group insurance market negotiate discounts from doctors and hospitals based not only on the small employer groups they cover, but rather, based on their entire block of business, including large employers as well as small groups. Because AHPs would represent small businesses only, it is unlikely that they could negotiate physician and hospital discounts that match or exceed those provided by health insurance plans covering both large and small employers.

Example of Premium Spike for Less Healthy Employer Groups

In order to fully understand the implications of the pending AHP legislation, it is important to focus on the fact that most States have adopted some variation of the National Association of Insurance Commissioners' (NAIC) model regulating rates in the small group market. The NAIC model limits rate variations—to no more than 25 percent above or below the average rate—for similar employer groups based on claims experience or health status. Moreover, this model limits annual rate increases for any one group to 15 percent on top of the rate increase applied to all groups.

The pending AHP legislation lacks this protection against wide rate fluctuations. That is, there is no limitation on what a group could be charged relative to similar groups based on health status or claims experience. The resulting rate swings would make small groups more vulnerable to catastrophic costs and make business planning less predictable.

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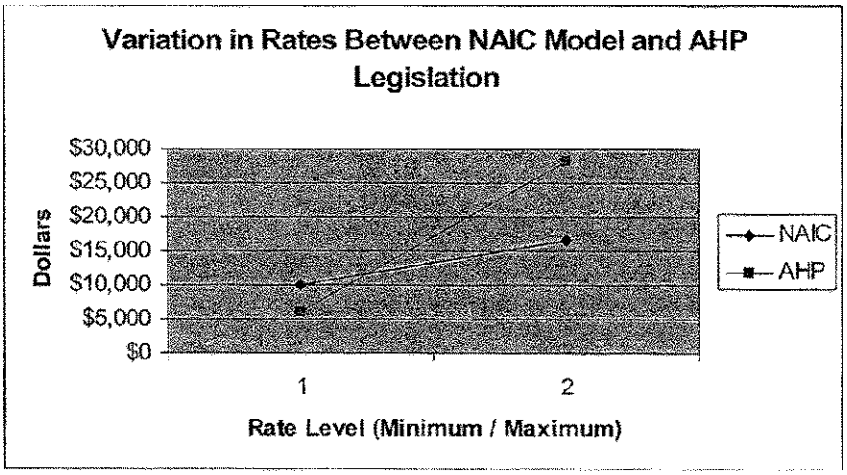
[7] U.S. Congressional Budget Office, Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts, Jan. 2000.

Here is a rating example based on modeling done by the Hay Group: Peterson's Hardware Store applies for insurance under a State law that has adopted the NAIC's approach of limiting rate variations based on health status. Peterson's is quoted an annual premium of between $10,000 and $16,667 (based on the maximum variation based on health status allowed under current law in most States). If the AHP rules were put in place, it would be quoted a rate between $6,000 and $28,226 (based on no limit to the variation allowed). Only the healthiest groups would be quoted the lowest level of rates. The graph below shows this variation.

If we assume Peterson's Hardware were eligible for the lowest rate, but someone became extremely ill during the year, the rates for the next year could change as follows. Under current law in most States, the rate could go from $10,000 to $11,500 (but no more), plus the overall trend increase—because the NAIC model limits rate increases based on changes in health status. Under the AHP model, the rate could go from $6,000 to the very top tier rate of $28,226 (plus trend), because there is no protection against annual increases based on health status.



This example illustrates that while low rates initially may seem attractive to small businesses with a healthy workforce, if one of their workers developed a significant illness, they would face a rate hike from the AHP the following year. Ultimately, the result would be a market in which a shrinking portion of healthy businesses would be covered by the AHP while businesses whose workers have significant health needs would be driven out of the AHP. This should be a major concern for all committee members.

We also urge the committee to consider the implications of allowing only certain entities—AHPs—to be exempted from State regulations. Congress should not create an unlevel playing field by granting special regulatory rules to specific entities that have little or no experience in the group and individual insurance markets. Federal legislative efforts should instead focus on creating consistent rules that address the affordability of health insurance coverage for all workers and their families.

Yet another serious concern is that preemption of State law for AHPs could repeat the problems of the late 1980s and early 1990s when Multiple Employer Welfare Arrangements (MEWAs) were exempted from State laws. The MEWA experience exposed thousands of individuals to unpaid medical bills and left them with no health insurance protection. Rather than repeat this history, we urge Congress to consider alternatives to AHP legislation.

Before closing, I want to briefly note that AHIP has launched a Web site—www.avoidfraud.org—which offers basic tips to help consumers avoid getting scammed by fraudulent, MEWA-like companies that claim to be health insurance plans. This site also provides consumers access to other relevant sources of information including the Web sites of their local State regulatory authorities.

Experience demonstrates that our industry can play a significant role in providing purchasers with coverage alternatives that are affordable and effective. To the extent that State legislation continues to be a barrier to fulfilling that goal, we urge you to consider a legislative approach that solves this problem broadly, rather than giving preference to an untested product based on a model that has had such unfortunate unintended consequences in the past.

CONCLUSION

AHIP and our member companies look forward to working with the committee to develop legislative solutions for meeting the healthcare needs of small employers and their workers. Our members have been working on creative strategies to make health coverage more affordable in the small-group market in a way that would avoid the many problems associated with AHPs. We are eager to share our ideas and contribute to a constructive debate on this issue.

Thank you again for providing AHIP the opportunity to testify on this important legislative priority.

The CHAIRMAN. Commissioner Praeger?

Ms. PRAEGER. Thank you, Mr. Chairman. It is a pleasure to be here with you this morning to represent my views and the views of the National Association of Insurance Commissioners, and it is a pleasure to be here with the other committee members as well.

The NAIC represents the chief insurance regulators from the 50 States and the District of Columbia and 5 U.S. territories. The primary objective of insurance regulators is to protect consumers, and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular the proposal to create association health plans.

Commissioners recognize how important it is to ensure that businesses have affordable and available healthcare coverage. Insurance is about spreading and sharing risk and not segmenting it. This is why the States have acted aggressively over the past 15 years to stabilize and to improve the small group market. States have required insurers to pool all of their small group risk by imposing rating bands to further spread the risk of smaller and unhealthier businesses across the larger population. States have created purchasing pools and allowed associations to provide licensed, State-regulated insurance products to their members.

States continue to experiment with such initiatives as reinsurance, tax credits, subsidies, basic health plans for small businesses, and programs to promote healthier lifestyles and to manage diseases. As always the States are and continue to be laboratories for innovative ideas.

I believe it is time to start looking at additional alternatives and in fact the States have been. For example, in Kansas this year our Governor announced a $50 million Healthy Kansas Initiative to expand coverage for 40,000 children and 30,000 working parents to find ways to control cost through more risk sharing among small businesses and to improve the availability of generic drugs for low-income individuals, and increase the awareness of obesity and other preventable chronic conditions.

As part of this initiative we in our department are working on a model, modeling reinsurance as part of a small group reinsurance feasibility study. Four alternative reinsurance mechanisms will be modeled with varying assumptions to quantify the impact of each on premium cost and small employer take-up rates in the Kansas market, and we actually are using actual claims data to do this modeling, and I think it is the first time something like this has been undertaken.

One of the most recent efforts along this line is the Healthy New York, which utilizes a retrospective reinsurance mechanism, subsidized by State tax dollars, and this has resulted in 70,000 new

insureds in the State, all low-wage workers and small businesses who were formerly uninsured.

Let me just go over now some of the principles that at the NAIC we have agreed on when we are looking at Federal reform. At the Federal level the Nation's insurance regulators have identified 7 basic principles by which Federal health insurance reform legislation can be analyzed. These principles are intended to keep the focus on the needs of consumers and the true causes of the current crisis.

1. The rights of consumers must be protected. So whatever we do, we have to remember that we need to make sure we are protecting consumers.

2. Existing State reforms and assistance programs must be supported and not degraded. So reforms need to recognize the good things that have happened in the States and not supplant those.

3. Adequate consumer education must be provided.

4. The overarching issue of rising healthcare costs has to be addressed.

5. Current cost shifting must not be exacerbated. And it is prevalent, it is part of the problem. We know it is existing, and whatever we do, we cannot create more opportunities for cost shifting as we try to find solutions.

6. The position of less healthy individuals must be protected. We cannot price them out of the marketplace as we try to find solutions.

7. Public policymakers should be aware of allowing the creation of insurance companies without appropriate oversight. There are over 10,000 insurance regulators in the States, and I can tell you as one of them, we have many phone calls on a daily basis, and over 50 percent of our phone calls daily are relating to insurance and availability and affordability of insurance. We do interact with our consumers on a very active and very daily basis.

The Nation's insurance regulators oppose association health plan legislation because it would violate these principles that we have set forth. It would undermine State reform and return a time when companies with sick workers were rated out of the market. It would eliminate critical State solvency and licensing rules for self-insured plans, resulting in increased plan failures and more fraud. It would replace sound State oversight with unfunded and inexperienced Federal oversight while trusting mostly in the plans to self report any problems. And it would preempt important consumer protections and cut funding for State high-risk pools and guaranty funds.

Studies have shown that this legislation will actually increase premiums for a majority of small businesses, and I have seen the report, the CBO report that Ms. Ignagni just referred to. This bill does nothing to address the rising cost of healthcare and it shifts the costs onto those with higher risks. So I do not believe, and the NAIC does not believe that this is a step forward.

So in conclusion just let me say all of us recognize it is very important to make health insurance available to small employers. That is the segment that we all know in our States is suffering the most. However, the problem is complex, and it does not lend itself to easy solutions.

The Federal Government and the States need to work with providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable. We stand ready to work with our colleagues and the Members of Congress to draft effective reforms that will address both affordability and the availability issues facing small businesses. Together we are convinced that real solutions to this critical issue can be found.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Praeger follows:]

PREPARED STATEMENT OF THE HONORABLE SANDY PRAEGER

INTRODUCTION

Good morning Mr. Chairman. My name is Sandy Praeger and I am testifying today on behalf of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 States, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular the proposal to create Association Health Plans (AHPs).

To begin I will emphasize the commissioners' recognition of how important it is to ensure affordable, available health coverage for small businesses and offer the full support of the NAIC in developing legislation that will reach these goals. States have acted aggressively over the past 15 years to stabilize and improve the small group market. States have required insurers to pool all of their small group risk by imposing rating bands or limitations, to further spread the risk of smaller, unhealthier businesses across a larger population. Many States have created purchasing pools and allowed associations to provide licensed, state-regulated insurance products to their members.

States continue to experiment with reinsurance, tax credits, subsidies, basic health plans for small businesses, and programs to promote healthier lifestyles and manage diseases. As always, States are the laboratories for innovative ideas. It is critical that the Federal Government and the States work closely with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. Rehashing strategies that have failed, such as Association Health Plans, is not a step forward. It's time to move on to find effective solutions.

NAIC's Principles for Federal Reform

In their search for effective solutions, the Nation's insurance regulators have identified seven basic principles by which Federal health insurance reform legislation can be analyzed. These principles are intended to keep the focus on the needs of consumers and the true causes of the current crisis. These principles are:

Principle 1: The rights of all consumers must be protected. States already have patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; unless new Federal standards equal or exceed existing State standards and enforcement they should not be preempted. Any new insurance arrangement purporting to increase the number of people with health insurance will be a failure if the insurance arrangement is not solvent and cannot pay the claims of those who have placed their trust in it. Further, all new proposals must preserve access to sufficient grievance and appeals procedures, and also assure that benefits and provider networks are adequate. Consumers must always be protected from fraud and misinformation.

Principle 2: Existing State reforms and assistance programs must be supported, not degraded. As you know, States have already enacted small group purchasing pools, high-risk pools, and other reforms to increase the availability and affordability of health insurance. Federal reforms must not erode these successful efforts by permitting good risk to be siphoned off through manipulation of benefit design or eligibility for benefit provisions.

Principle 3: Adequate consumer education must be provided. Federal reform will be complicated, creating new insurance choices for many Americans. The Federal Government must coordinate with existing State consumer education programs to ensure consumers are able to make informed choices.

Principle 4: The overarching issue of rising healthcare costs must be addressed. Federal efforts to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising healthcare costs is also addressed. Insurance is a mechanism for paying for healthcare and has had only limited success in controlling costs, but insurance is not the cause of those skyrocketing costs. There are multiple drivers of healthcare costs, and they in turn are driving up the cost of health insurance. To bring long-term stability to the healthcare system efforts must include provisions to address cost drivers and control rising healthcare costs.

Principle 5. Current cost shifting must not be exacerbated. Inadequate reimbursement payments have led to cost shifting to the private sector. Unfunded Federal mandates to States have shifted costs onto State Governments. The cost of providing care to the uninsured is also shifted, driving up rates for insurance consumers. These actions have resulted in higher overall costs and decreased access for many consumers. Federal health insurance reform legislation must address cost shifting.

Principle 6: The position of less healthy individuals must be protected. Both State and the Federal Governments have begun the process of reforming tax structure and other financial policies to encourage individuals to be more responsible consumers of healthcare. Emerging industry trends reflect developments in benefit and plan designs that create incentives for responsible consumer behavior in healthcare purchasing decisions. Public policy decisions must assure that new designs do not shift costs to such an extent that insurance no longer offers meaningful protection to the sick or discourage appropriate care. Federal legislation should encourage appropriate usage of the healthcare system without inappropriately withholding needed healthcare services to the sicker patient.

Principle 7: Public policymakers should be wary of allowing the creation of insurance companies without appropriate oversight. Remember, legislation that allows alternative risk-bearing arrangements must acknowledge that it is allowing the creation of new insurance companies. A mere change in the name of the arrangement does not transform its essential insurance nature and function—the acceptance and spreading of risk. To allow such new insurance companies to be formed outside the existing regulatory structure will create an unlevel playing field that is unfair to existing insurers and potentially harmful to consumers. To do so without providing adequate additional Federal resources to ensure sufficient oversight of new entities will be disastrous.

AHP Legislation Violates NAIC Principles

The AHP legislation that has been once again introduced in the House and the Senate violates almost all of the principles outlined above and, therefore, the NAIC must remain steadfast in its objections to the AHP bills. Specifically, the legislation would:

1. Undermine State Reforms

Before State small group market reforms were implemented, the small group market was fragmented into various pools based on risk. If a small employer had healthy employees in a relatively safe working environment the employer could easily find coverage at a good rate. However, if one of the employees became sick, the employer would be shifted to a higher risk pool and often priced out of coverage. Those who started with sicker or higher risk employees were often priced out of the market from the beginning.

State small group market reforms forced insurers to treat all small employers as part of a single pool and allow only modest, and in some States no, variations in premiums based on risk. This spreading of risk has brought some fairness to the market. Although the proponents claim AHPs are a vehicle for allowing small businesses to pool together, they would actually reduce the amount of pooling in the small group market. In fact, it is not pooling but "cherry picking" that would enable AHPs to offer lower-cost coverage in some cases. Such savings would come at the expense of all others in the small group market who are not part of AHPs. The AHP legislation in Congress would undermine State reforms and once again fragment the market.

While the AHP bill does make some effort to reduce "cherry picking" the NAIC believes the provisions will be ineffective in stopping risk selection. Under the current bill, AHPs can still "cherry-pick" using four very basic methods:

(a) Membership—S. 545 permits associations to offer coverage only to their members, allowing plans to seek memberships with better risk;

(b) Rating—S. 545 eliminates State rating limits for most plans, allowing them to charge far more for higher risk persons, forcing them out of the pool;

(c) Service area—S. 545 eliminates State service area and network requirements, allowing plans to "redline" and avoid more costly areas;

(d) Benefit design—S. 545 eliminates all State benefit mandates, allowing plans to cut prices by denying consumers costlier treatments, driving employers whose workers need these treatments into the regulated market while siphoning off employers with healthier workforces.

If no cherry picking were possible, AHPs would attract a risk pool that, on average, was the same as the current small group market—which would take away a major advantage of forming AHPs. Assertions by proponents of this measure that this issue has been addressed are incorrect.

2. Lead to Increased Plan Failures and Fraud Due to Inadequate Oversight

Proponents of the AHP legislation claim that the Department of Labor has sufficient resources to oversee the new plans and insolvencies and fraud will be prevented. This simply is not the case. The Department of Labor has neither the resources nor the expertise to regulate insurance products. The States have invested more than 125 years in regulating the insurance industry. State insurance departments nationwide employ over 10,000 highly skilled people. The combined budgets of State insurance departments total more than $700 million. The AHP bill provides no new resources for regulating these plans.

While the NAIC acknowledges State regulation may cost slightly more initially, those costs are offset by the protections provided to our consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed.

This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-state association plans, out-of-state trusts, and other schemes to avoid or limit State regulation. Within the last year, 16 States have shut down 48 AHP-like plans that had been operating illegally in those States, many through bona fide associations. Association plans in several States have gone bankrupt because they did not have the same regulatory oversight as state-regulated plans, leaving millions of dollars in provider bills unpaid and consumers liable for their payment.

Each time oversight has been limited the result has been the same—increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims. Specifically, the NAIC believes the following issues must be addressed:

a. Solvency Standards Must Be Increased—While the solvency standards in the AHP legislation have been increased over the years, they are still woefully inadequate. The capital reserve requirement for any and all AHPs is capped at $2 million—no matter the size of the plan. States require the capital surpluses to grow as the plan grows, with no cap or a far higher cap than that in the Federal legislation. If a nationwide AHP were offered to a large association, a capital surplus of merely $2 million would result in disaster.

b. AHP Finances Must Receive Greater Oversight—Even if the solvency standards are increased, oversight is almost nonexistent in the bill. Under the bill the AHP would work with an actuary chosen by the association to set the reserve levels with little or no government oversight to ensure the levels are sufficient or maintained. Also, the AHP is required to "self-report" any financial problems. As we have seen over the past few years, relying on a company-picked accountant or actuary to alert the government to any problems can have dire consequences for consumers who expect to have protection under their health plan.

State regulators comb over financial reports and continually check investment ratings to ensure that any potential problems are identified and rectified quickly. AHP plans must be held to the same standard.

Simply limiting participation in AHPs to "bona fide trade and professional associations" and providing limited Department of Labor oversight of self-reported problems will not prevent fraud and mismanagement. Strict oversight is required and this will only occur if all health plans delivered through associations are licensed and regulated at the State level.

3. Eliminate Important Consumer Protections

Included in the current AHP legislative proposals is the broad preemption of consumer protection laws. AHP proponents argue that State mandated benefit laws must be preempted so that AHPs do not have to provide coverage for expensive benefits. However, States have a multi-faceted regulatory structure in place for insurers. Not only are mandated benefit laws preempted, but other laws protecting patient rights and ensuring the integrity of the insurers are preempted as well. Here is a small sample of preempted consumer protections:

• Internal and external appeals processes.
• Investment regulations to ensure that carriers only make solid investments instead of taking on risky investments such as junk bonds.
• Unfair claims settlement practices laws.
• Advertising regulation to prevent misleading or fraudulent claims.
• Policy form reviews to prevent unfair or misleading language.
• Rate reviews. Insurance departments may review rates to make sure the premiums charged are fair and reasonable in relation to the benefits received.
• Background review of officers.
• Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.
• Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a patient's rights are violated by the plan. State insurance regulators act on hundreds of thousands of consumer complaints every year and work hard to protect the rights of patients. AHP participants deserve access to the same protections and complaint process.

4. Cut Funds to State High-Risk Pools and Guaranty Funds

While the latest version of the AHP legislation allows States to impose premium taxes on AHP plans—to the extent they are imposed on other insurance plans—it preempts other State assessments. States use health insurance assessments to fund such important entities as high-risk pools (which provide coverage to the uninsurable) and guaranty funds (which help cover claims if a plan is insolvent.) Such programs are vital to the stability of the small group and individual markets and to the protection of consumers—they must not be undercut by Federal preemption.

Alternatives for Real Reform

If this hearing is truly about alternatives to our healthcare needs, then it is time to look at alternatives. As you know, States have been the laboratories for innovative ideas in this arena for some time. In Kansas, the Governor announced a $50 million HealthyKansas initiative to expand coverage for 40,000 children and 30,000 working parents; find ways to control costs through more risk sharing among small businesses; improve availability of generic drugs for low-income individuals; and increase awareness of obesity and other preventable chronic conditions. As part of this initiative, we are modeling reinsurance as part of a small group reinsurance feasibility study under a HRSA State Planning Grant. Four alternative reinsurance mechanisms will be modeled with varying assumptions to quantify the impact of each on premium cost and small employer take-up rates in the Kansas market. There are four reinsurance approaches that we will model, two prospective and two retrospective. The prospective approaches will follow NAIC small group reinsurance model and Connecticut designs and the retrospective will follow Healthy New York and a diagnosis-based design considered by Colorado. We then intend to select the most effective reinsurance approach that will control claim fluctuations and risk acceptance by carriers. Since we will be using our reinsurance system to process 5 years of actual Kansas claim data we will be able to project the amount of subsidy that actually could be provided in future years given different levels of subsidy.

Other States have experimented with reinsurance, tax credits, subsidies, basic health plans for small businesses, public program expansion, and programs to promote healthier lifestyles and manage diseases. Many States utilize reinsurance mechanisms in the small group market, with various degrees of success. The most recent effort by the State of New York in its Healthy New York program has utilized a retrospective reinsurance mechanism, subsidized by State tax dollars, that has resulted in about 70,000 new insureds, all low wage workers in small businesses who were formerly uninsured.

As another example, in Maine, the State enacted the Dirigo Health Plan, intended to provide coverage for 180,000 State residents. The plan has two components: (1) expansion of Medicaid and SCHIP to parents with incomes up to 200 percent of the Federal poverty line and to everyone earning less than 125 percent of the Federal poverty line; and (2) establishment of a public/private plan to cover businesses with 2–50 employees, the self-employed, and unemployed and part-time workers. The plan is in its early stages of implementation, and State policymakers have high hopes for its success.

CONCLUSION

All of us recognize that it is very important to make health insurance available to small employers. The States have begun to address this problem, and will continue to do so. However, the problem is complex and does not lend itself to easy solutions.

The Federal Government and the States need to work with healthcare providers, insures and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. We stand ready to work with Members of Congress to draft effective reforms that will address both the affordability and availability issues facing small businesses. Together, we are convinced, real solutions to this critical issue can be found.

The CHAIRMAN. Thank you to the entire panel. I appreciate the condensation that you did on your remarks. I will assure you again that your remarks in their entirety will be a part of the record, and also we will keep the record open for 10 days after this hearing is over so that members of the panel can add additional questions in writing, which I hope you will respond to so that we can complete the record, and that will be done by both ones that are here and ones that may not be here.

I would mention that Senator Kennedy had fully intended to be at this hearing this morning. Unfortunately, he is at the ongoing Executive Session in the Judiciary Committee, and those are taking quite a bit of time sometimes these days. He has asked me to thank the witnesses for their testimony, and I ask unanimous consent that his statement be a part of the record. Without objection.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

I commend Senator Enzi for holding today's hearing on healthcare for employees of small businesses.

In this century of the life sciences, it's unconscionable that the miracles of modern medicine are too often beyond the reach of all but the wealthy.

Healthcare costs are out of control and more and more Americans are losing their insurance. Forty-five million Americans today have no health insurance. We know that persons without coverage receive less care, suffer more, and are more likely to die than those who are insured.

The vast majority of the uninsured—more than 80 percent—are members of working families. More than half are employees of small businesses or their family members. All businesses—especially small firms—find it harder and harder to provide coverage for their workers. Health insurance premiums have risen 59 percent over the past 4 years, and the average cost of coverage for a family today has climbed to almost almost $10,000.

Some favor association health plans, but they have many problems. States across the country have enacted significant protections for consumers in health insurance plans—but association health plans would sweep those protections aside. Gone would be requirements to cover needed benefits like maternity care, child immunizations and cancer screenings. Study after study shows that the way such plans save money is by avoiding State consumer laws and State rating rules, putting patients at risk.

A basic principle for every responsible health insurance plan is adequate financial resources to meet its obligations. But associa-

tion health plans have much weaker solvency requirements and are clearly inadequate to protect consumers. We have extensive experience with health insurance sold through associations and other types of "multiple employer welfare arrangements," and they've had many problems over the years. Thousands of Americans have been left in financial ruin when their association plan has failed. In recent years, four large groups—two in New Jersey, one in Indiana, and one in California—have failed, leaving $45 million in claims unpaid for the 65,000 persons covered by the plans.

The bottom line is that such proposals will do virtually nothing to reduce the number of the uninsured, and will actually cause premiums to rise for over 20 million employees and their families, according to the Congressional Budget Office. Small businesses with young and healthy workers may be attractive customers for such plans, but those with older employees or employees with serious health conditions will be left behind. A "solution" that offers no help to those most in need is no solution at all.

That's why such plans are opposed by the the National Governors Association, the National Association of Insurance Commissioners, the National Conference of State Legislatures, the American Cancer Society, the American Diabetes Association, the American Academy of Pediatrics, the NAACP and more than 1,300 other organizations that represent patients, healthcare professionals, consumers and workers.

We need to make affordable healthcare a top priority for all families, including those working in small businesses. That's why I support an approach that would provide access to good health coverage for all Americans, regardless of where they work. I call it "Medicare for All."

To promote competition and choice, enrollees could join Medicare, or have the option of choosing any of the plans offered to Members of Congress, the President, and Federal employees.

Healthcare for all is our goal, and an important step toward reaching it is to help small businesses provide quality healthcare coverage—but association health plans have too many flaws to justify our support.

I look forward to the recommendations of our witnesses and to working with the Chairman and our colleagues to find a realistic bipartisan solution to this major problem.

The CHAIRMAN. I would mention too that he does a great deal of work on being informed on what goes on in these meetings and a great deal of preparation that he now will not be able to take advantage of, but I do appreciate his cooperation and participation on these issues.

I also have a statement from Senator Snowe and from Senator Talent, and would ask unanimous consent to add them to the record. Without objection.

[The prepared statement of Senator Snowe follows:]

PREPARED STATEMENT OF SENATOR SNOWE

Thank you Chairman Enzi, for holding this hearing today on the health care crisis that faces small businesses. As you know, just yesterday the committee on Small Business and Entrepreneurship hosted a hearing on association health plans (AHPs) and other solutions for the health care crisis. We had a positive dialogue about AHPs, and I am pleased that the HELP Committee, which has jurisdiction over

AHP legislation, has also decided to take up this issue. I believe that there is incredible momentum surrounding AHPs!

I originally examined this issue 2 years ago during the very first hearing I conducted as chair of the Committee on Small Business and Entrepreneurship, and regrettably, since then the problem has only grown worse. Today, I hope that the HELP Committee will probe deeper into solving this crisis, and hopefully jump start real action by Congress to enact solutions this year.

This hearing will focus on association health plans—"AHPs"—which I strongly believe can play a major role in addressing this country's health care crisis. Touted by President Bush and supported by over 80 million Americans, AHPs will bring necessary reform to insurance markets that have long trapped small businesses and their employees in a vicious cycle of escalating premium costs and fewer coverage options. AHPs are crucial to solving the small business health care crisis because they represent a fair, fiscally sound, and already tested approach to reducing the ranks of the uninsured in this country at nominal cost to the Federal Government.

Of the nearly 45 million uninsured Americans, 62 percent of the uninsured are either employed by a small business or dependent on someone who is. If we want to get serious about helping the uninsured, which I think is long overdue, we should start by focusing on small business.

The USA Today recently identified health insurance costs as the number one issue facing small business employers across the country, a fact confirmed in the National Federation of Independent Business's Small Business Economic Trends monthly report from March. Almost 30 percent of the small business owners surveyed responded that cost and availability of insurance was the single most important problem facing small businesses today. This was far and away their most pressing concern and it's one I've heard time and time again.

Indeed, these surveys and studies mirror what we hear everyday from small business owners across the country. At our hearing yesterday, we heard from Doug Newman, a concrete company owner from Hallowell, Maine, who has described premium increases of close to 65 percent since 2000.

The time has come for action, not words, to deliver small business owners relief from this crisis. AHPs do this, with a common sense approach that allows small employers to join together through bona fide associations to buy health coverage. AHPs will level the playing field of employer health coverage by giving participating small employers the advantages of Federal law currently enjoyed by larger employers and unions.

AHP's have the strong support of President Bush, as he has said in his last two State of the Union addresses, and the Majority Leader, Senator Frist, has indicated he would like to see floor action on AHPs this year and I appreciate his support. AHPs are supported by a coalition representing over 12 million employers and 80 million individuals.

Moreover, a recent snapshot poll in the USA Today asked 2,076 CEOs, "What changes to health care policies could be made that would have the greatest impact on your business?" The number one response, at 56 percent, was consolidated group rates—pooling, just as is recommended in my AHP legislation—for small businesses.

Today, I hope the HELP Committee will examine the truths and realities involved with AHPs, and to finally—once and for all—drive a stake into the myths that opponents have put forth about AHPs over the years.

AHPs allow small businesses to pool their employees together to receive the same bulk purchasing and administrative efficiencies already enjoyed by large employers and unions. It builds on the success of the ERISA self insurance plans used by large employers and the Taft-Hartley plans available to union employers, which currently provide health benefits for 78 million people, more than half of the people who receive health insurance from their employer.

Our aim is to inject competition in the marketplace and offer alternatives to small businesses trapped in the current system. Associations will be able to administer one national plan, with lower administrative costs.

And reducing costs for small businesses is why we are here today. Studies by both the GAO and the Small Business Administration's Office of Advocacy concluded that small businesses currently absorb a greater portion of their plans' administrative costs, paying as much as 20 to 30 percent more in total premiums than larger health plans. As a result, small business receive less generous benefits than larger employers while paying the same level of premiums. On both counts, small businesses and their employees lose.

The Kaiser Family Foundation recently reported that between the spring of 2003 and spring of 2004, health insurance premiums increased 11.2 percent. This marked the 4th consecutive year of double digit increases! Health insurance premiums saw

annual increases since 2000 of 10.9 percent, 12.9 percent, and 13.9 percent, respectively—a growth that far outpaced inflation and erased wage gains.

AHP legislation will also provide a full range of benefits similar to what many States currently require. In many cases, large employers and unions, which are exempt from State benefit mandates, offer the most generous plans. Not surprisingly, many employees actually choose to stay in their jobs only to maintain that higher level of coverage. Like these larger plans, this bill's extensive new safeguards will ensure that the health care coverage is available when employees need it, as well as prevent fraud.

Contrary to opponents of this bill who claim it would lead to "cherry picking" of only the young and healthy, this AHP bill specifically require that associations plans must be open to all members. And each employer who participates in the plan must offer the plan to every eligible employee—at the risk of fines and even imprisonment of up to 5 years.

Finally, critics claim that the Department of Labor could not handle its responsibilities under this bill. Frankly, I cannot imagine an agency better prepared than the Labor Department which currently oversees 300,000 similarly structured plans. We rarely hear complaints about these plans failing and leaving subscribers without coverage. AHPs would not add an unmanageable burden to DOL, and as the Secretary of Labor will testify, sufficient resources would be available to ensure that the Department fulfilled its obligations.

AHP legislation is one excellent reform among myriad solutions to the healthcare crisis but it is one that should be available to start making a difference immediately—this is not radical new policy we're talking about here! We should also examine ways to use the tax code as a mechanism for increasing access to health care, and that is why I recently introduced a bill with Senators Bond and Bingaman to enable more small business owners to offer a choice of a "cafeteria plan" to allow employees to purchase health insurance with tax-free dollars. Currently, many small employers' hands are tied by arbitrary rules that restrict cafeteria plans based on the size of a business. Our bill would simplify those rules and give more small businesses greater flexibility to meet the healthcare needs of their employees—and that, after all, is our goal.

I look forward to hearing from the witnesses today and working with the President and my colleagues to reduce the ranks of uninsured Americans. Let me emphasize that while I believe that passage of AHP legislation is an indispensable step toward resolving the small business health care crisis and indeed the broader crisis of the insured, I am eager and willing to work with colleagues to address concerns about this legislation and craft the best possible solution.

Again, Chairman Enzi, thank you for holding this hearing, and for giving me the opportunity to submit testimony into the hearing record on association health plans and the health care crisis facing small business.

[The prepared statement of Senator Talent follows:]

PREPARED STATEMENT OF SENATOR TALENT

I would like to thank Chairman Enzi for holding this important hearing, and for inviting me to make a statement for the record.

I think we can all agree that a major concern facing small business owners is access to quality, affordable health care. Of the 45 million Americans who lack health insurance, more than 80 percent are workers and their families and 60 percent are small business people and their families. I've talked personally with hundreds of people in small businesses, and they tell me how they are desperate for affordable, high-quality health insurance.

I spoke with Janet Poppen, a small business owner from St. Louis, who, like many small business owners, wants to do right by her five employees and provide them with health insurance. Over the past 2 years, the insurance costs for Janet's company have increased by $431 per month, or a total increase over the 2 years of 35 percent (from $1,237 in 2001 to $1,668 per month in 2003). Instead of Janet denying her employees health insurance or making business upgrades, she has reduced her own salary.

Like most small business owners, any health insurance cost increases affect Janet's take home pay, but she is willing to pay the price because she wants to do right by her employees and provide them with health care. Small business owners like Janet believe AHPs would reduce their administrative and other costs so they will no longer have to pay the marketing costs or profit margins of insurance companies and, instead, invest in their own companies.

Perhaps it comes as no surprise that insurance companies like the national Blue Cross and Blue Shield Association do not like AHPs. One would guess that these

insurers would welcome AHPs as an opportunity to make a lot of money by selling tens of thousands more policies. But that does not seem to be the case. Why not? Because insurers have a monopoly on health insurance through their ironclad grasp of market share.

The General Accounting Office has found that the five largest carriers combined represent 75 percent or more of the market in 19 of the 34 States GAO reviewed. In Missouri the five largest carriers have a 51.8 percent market share. AHPs will make health insurance more affordable for small business through reduced premiums, to create more competition in the small group market—and that will bring costs down for the consumer.

The Congressional Budget Office has estimated that small businesses obtaining insurance through AHPs should experience premium reductions of 13 percent on average and up to 25 percent. That's just over $1,000 to more than $1,900 for the average family health plan offered by a small business. Clearly, these reductions are going to hurt the bottom line of insurance companies and reduce their stranglehold on small business purchasing options.

On the flipside, AHPs will provide affordable, quality health insurance to small business owners, their employees and dependents across our Nation. The smallest firms stand to save the most from AHPs because their administrative costs, which account for a significant percentage of their expenses, will decrease.

A January 2003 Small Business Administration actuarial report shows that administrative expenses for insurers of small health plans make up 33 to 37 percent of claims. This compares with about 5 to 11 percent of claims for large companies' self-insured plans.

Because insurance would be more affordable, more small firms could provide it to their employees and families. According to the CONSAD Research Corporation, as many as 8.5 million previously uninsured workers would receive coverage if this legislation were enacted into law. And, importantly, Association Health Plans will unburden small business owners from worrying about how to provide health care to their employees owners to doing what they do best—running their businesses.

Now, I have heard several myths to dispute how much good Association Health Plans will provide small businesses. I would like to set the record straight right now:

Myth: Association Health Plans will allow organizations to "cherry pick" only the healthiest individuals, leaving the States' small group markets to care for the sickest individuals.

FACT: AHPs are prohibited by law and the language of this bill from being able to "cherry pick."

The legislation clearly states that the bona fide association must provide all interested employers (regardless of age, health status, etc.) with information regarding all coverage options available under the plan. AHPs would be subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under the Health Insurance Portability and Accountability Act.

Also, the bill clearly prohibits discrimination based on health status by stipulating any member of an association who is eligible for membership benefits must be furnished with information regarding all coverage options available under the plan and may not be excluded from enrolling in the plan because of health status. Thus, it will *not* be possible for AHPs to "cherry pick" because sick or high risk groups or individuals cannot be denied coverage.

Myth: AHPs lack adequate solvency protections.

FACT: The legislation contains extensive requirements for solvency.

Health insurance issuers that offer fully insured coverage to AHPs will continue to be subject to State laws regarding solvency. In addition, the U.S. Department of Labor would condition its class certification of fully insured AHPs on the issuer's satisfaction of State solvency and other insurance regulations.

With respect to self-insured AHPs, the legislation sets forth explicit solvency requirements that are much stronger than current law for employers or unions who self-insure, as ERISA contains no solvency standards for these entities.

Myth: AHPs will destroy consumer protections by preempting all State benefit mandates and regulations.

FACT: The preemption of State mandates is an integral aspect of ERISA.

The solvency standards, plan requirements, oversight, and patient protections included in the AHP legislation are more stringent than those now required by some States. AHPs would be subject to Federal health insurance requirements that provide consumer protections, such as COBRA continuation coverage; ERISA's claims procedures for benefit denials and appeals; HIPAA's guaranteed portability and re-

newability of health coverage for those with preexisting conditions; the Mental Health Parity Act; the Women's Health and Cancer Rights Act; and the Newborns' and Mothers' Health Protection Act. Because it operates in the interest of its members, AHPs will readily cover benefits demonstrated to be cost-effective, such as childhood immunization, prenatal care, and cancer screenings.

These are just some of the pro-patient, pro-consumer protections contained in S. 406. For these and other reasons, AHPs are strongly supported by more than 170 organizations representing over 12 million employers and 80 million American workers.

We need to work together now to pass a package of ideas that will make a real difference for people without health insurance and help lower the cost of health care for everybody. Again, I thank HELP Committee Chairman Enzi for his leadership and for his receptivity to common sense solutions like Association Health Plans.

The CHAIRMAN. I want to thank all of you for the ideas that you put forward, and we do have a few questions, and I would say that this is not just a small business problem either. I noticed yesterday that General Motors was saying that they are now putting more into their insurance than they are into steel in the cars that they build. So it goes all the way up the chain, but of course, as with everything, it affects the small businesses considerably more than it affects the big businesses.

Mr. Blake, I really appreciate your setting the stage for that discussion. We are very fortunate in Wyoming to have a special high-risk insurance pool and to have the ability to move some people into it. I do not know where your rates would have gone otherwise. We will try to come up with, through these discussions and others, some kind of a mechanism that will help companies like yours. I know that yours is not an isolated case, and it does create a lot of turmoil. So as you have any ideas, we will appreciate you sharing them with us.

I am going to concentrate a little bit on some of the statements that were made here. Many of my colleagues and I have been asking the opponents of the AHP legislation to step forward with some real alternatives for addressing the small business insurance problem, and I am encouraged by the serious testimony that we have had here today. However, I would like to ask Ms. Ignagni and Commissioner Praeger the following.

Of the alternatives or modifications to AHPs that you have looked at, what are the top two or three strategies that you would urge this committee to consider as we work on easing costs and improving access for small business? Ms. Ignagni?

Ms. IGNAGNI. Thank you, Senator. I am delighted to answer that question. The first thing I think that is important to look at is the issue—I also heard the leader of GM make that statement, and I think that that requires all of us to look very closely at—are we getting value for the considerable healthcare investment?

When the national data suggests that only 55 percent of what is done is best practice, in any other area of the economy if we had that situation it would be a catastrophe. And it is because we do not have data or transparency in the healthcare system to really get our hands around what is being done at the beside in specific care. And frankly, physicians who are very busy every day cannot spend every night looking through medical journals to determine best practices. So I think a very tangible set of solutions is as follows.

No. 1: As you look at the budgets of the National Institutes of Health, we look at the fact that we have the best research capacity in the world, but we are doing next to nothing to diffuse that in an organized way into practice. So physicians simply do not have access to what is being done in clinical trials, to be kept abreast of the latest information, so when we see these data it is not surprising. But I think that here should be a requirement, either through the National Institutes of Health or the Agency for Health Care Quality and Research, to act as a diffusion mechanism to get that information, set up a center for effective best practices.

I think that is something that all stakeholders can get behind, and I think you could see tangible results, just as we would look at a productivity or production function issue or deficit in a manufacturing sense. It is a similar kind of analogy. So that is No. 1.

No. 2: I think it is very important—and I understand the passionate feelings around the issue of medical malpractice reform, but when we are looking at $100 billion on defensive medicine, that is something that even if you take 50 percent of that, and we had 50 billion to reorient to tax credits to help companies like Mr. Blake's afford affordable healthcare coverage, particularly oriented to small business, low-wage workers, etc. We know that approximately 12 million workers are offered coverage and cannot afford to take it. So that is a second strategy.

The third is that I think that it is very important now to have a discussion both with the National Insurance Commissioners and their association and leaders on Capitol Hill about modernizing the regulatory structure. Looking at what stands in the way of offering affordable products, how we can begin to have more harmonization and uniformity of regulation, work through the challenges and come up with a strategy.

So we would like to be part of that. We have already begun that process with the NAIC. We have begun it with your colleagues both here as well as in the House, and we want to be solution providers to sorting through that.

And then there are other issues which I am pleased to tell you we are having an effect on. We have taken pharmaceutical rates of increase that just 2½ years ago were above 20 percent. We have taken them well under 10. We have done that through a series of strategies, pharmaceutical care management, encouraging generic drug substitution when physicians say it is appropriate, step therapy, disease management. I have provided a series of things that we are doing that we are seeing results on, some hard, tangible data, not ours, but peer-reviewed data about disease management, etc. I think all of these strategies work together.

I think, finally, the important legislation you passed out of this committee to give States a helping hand with high-risk pools of the sort that you have in Wyoming. Thirty-three States have high-risk pools. It is a very, very important piece of legislation.

So I think taken together, Senator, I think that series of strategies could help shrink that balloon.

The CHAIRMAN. Commissioner?

Ms. PRAEGER. Thank you, Mr. Chairman. I think Karen makes a good point about this move toward best practices. I am often amused by the term "evidence-based medicine" because, you know,

that we are moving toward that evidence-based medicine, and you have to ask, gee, what were we doing before? And the truth is these were practices that have just developed over time, and they are very regionalized. A best practice in one part of the country may not be considered that in another part of the country, so there really does need to be a standardization and some way of getting that information out to providers to assist them in adopting these best practices.

Insurance is the messenger and the message is healthcare costs are going up. So we struggle to find ways to spread that cost over the individuals in the insured marketplace, but we have to address the cost of healthcare if we are going to decrease the cost or bring the cost of health insurance premiums under control.

One of the programs that we are testing in Kansas—and I mentioned it in my statement—is to look at the risk bands. That is the way we have traditionally spread the risk in a small group market. We are looking at a different way of spreading risk, and saying, let us seat out of each individual group the high-risk individuals, rate the group based on its healthy individuals, and then look at that entire pool of high-risk individuals and spread those costs back over each of those individual small groups.

It does a couple of things. It helps spread that cost in a different way, and I think perhaps a fairer way, because you do not have, as we just heard, one group with one high-risk individual and their premiums really become unaffordable for everybody. This would create I think a broader risk-sharing mechanism, and it also would bring some stability because your healthy individuals, that risk is not going to change much from year to year, but if you are rating a group based on just that group, you can have a healthy group 1 year and a very unhealthy and costly group the next. And so bringing some stability to the way we spread risk I think is important.

And I look forward to getting the data back. We are currently assessing the claims data on the top 20 carriers in our State to look at where the costs are and see if we can come up with a model that can work and be more cost effective.

I think there is another thing, a reason—now I do not know how we create a solution out of this—but certainly the reason that we see costs going up is all of the technology and the new technology that is available and is out there. We have a third-party payment system that has no discipline. If the consumer understands that there are certain tests or certain procedures or certain medications that they would like to have access to and they have insurance, there is no concern. I do not have to ask what that costs because my insurance will pay for it. Over time that drives the cost up for everybody. So bringing some discipline back into the system,

And I think health savings accounts, one of the reasons Congress passed health savings accounts was to bring a little bit more individual responsibility into making those purchasing decisions. We as consumers cannot make good decisions if we do not have good data, and I think a very good point that Karen also made, the transparency of information that is really going to be needed if we as consumers are going to be making good choices.

The CHAIRMAN. Thank you. Of course, one of my reasons for concern is, as the least populated State in the Nation, Wyoming may not even make a single pool.

[Laughter.]

Senator Ensign?

Senator ENSIGN. Thank you, Mr. Chairman. This is a very important hearing that you have called for today. Healthcare costs are one of the most significant problems facing our country, individuals and our Government. Medicaid and Medicare together dwarf the problems that we have for Social Security as far as unfunded liabilities for the future. If we do not start getting control of this spending now, our children and grandchildren will be in serious, serious trouble.

I want to talk a little bit about some of the things that Ms. Ignagni discussed and some issues that no one else has raised. Everybody talks about the problems associated with smoking and obesity. These are the two biggest health concerns—and the most preventable health problems that we have in the country. These two issues drive up healthcare costs more than anything else in the country. Nobody wants to see a little girl diagnosed with a brain tumor. There is nothing the girl did to cause the tumor. But with smoking and with obesity, well, for some people, obesity is not anything they can help, but for most of us, obesity occurs because the one exercise we do not do enough is this one—pushing away from the table.

[Laughter.]

It seems to me that we have to get a handle on preventative health in this country. We need to encourage people to adopt healthy behaviors. I do not know what role that plays in the ability of health insurance pools. With auto insurance, if I am a safe driver I should be able to have lower insurance rates. Similarly, if I engage in healthy activities, exercise regularly, and do not smoke, it seems to me that an incentive shoud be offered. It also seems to me that those incentives should be fairly large if we really want people to change their behaviors to pursue and maintain a healthy lifestyle.

If you could address healthy lifestyles and incentives for healthy plan design as well as best practices, I would appreciare it. Unfortunately, I do not have a lot of time because I have to preside at 11 o'clock on the Senate floor. I have an interest in the practice of evidence-based medicine. I believe we need to develop and encourage the use of best practices so that doctors and other healthcare professionals have the information they need to make appropriate clinical decisions. What can we do to better incorporate best practices into private health insurance programs and large government programs such as Medicare and Medicaid? And, can you please provide me with an estimate in terms of savings that could be achieved as a result of the incorporation of best practices? I do not know if any of you have any estimates on what the potential savings could be from the use of best practices, but best practices are clearly not being done in nearly enough areas.

I would also appreciate your comments concerning health information technology. Healthcare is one of the few areas where technology does not always bring the price of services down, it actually

brings the price up. However, it seems to me that, if properly implemented, health information technology will reduce duplication, and cut down administrative costs, such as transcription and billing. In addition, this technology will reduce medical errors and potentially reduce medical liability insurance premiums for physicians and other healthcare professionals. I know the focus of the hearing today is on association health plans, but that proposal is a controversial measure. I do not know if we are going to ever get something like that passed. However, some of these other ideas may warrant consideration and actually lower the cost of healthcare, not only for small businesses but for the General Motors of the world and obviously for Medicare and Medicaid into the future.

Ms. IGNAGNI. Thank you, Senator. You have asked a series of provocative questions, and I am going to give you—and in the interest of time try to be as quick as I can.

First, you are right about obesity. It is a very important factor in virtually every major chronic illness. What our health insurance plans are doing now is giving individuals incentives for healthy lifestyles, and I would be delighted to provide a laundry list of things that are going on. I think you will be excited. It is very much in line with what you have suggested.

Second, with respect to the issue of evidence-base in Medicare and Medicaid, Dr. McClellan has opened up an important new frontier in our view. He has started to begin to marry the concept of the clinical trials and what works evidence, and the scientific research with coverage policies. And he is launching a new effort in conjunction with the Institute of Medicine to collect data on the efficacy of certain devices, for example, so we can go back and look and adjust coverage policies. It is a very important new frontier, number one, and I think that that will reverberate throughout the whole system in a productive way.

No. 2, the incentives for best practice that you questioned about. We are working with a group of providers to try to create consensus around what should be measured for quality. The Institute of Medicine has been very clear about quality guidelines. What should be measured? Dr. McClellan is also looking at aligning incentives with the best practices so that he can reward physicians, hospitals for achieving productivity goals. There is a lot of enthusiasm within the physician and hospital community about this. Individual practitioners want to be recognized for excellence, so I am very encouraged about that. Our health plans are doing that as well. Again, I would love to provide some information for the record.

Finally, electronic records. We have under way a full court press within our industry because we have claims data, we have more data that can be useful to individuals in terms of assembling and giving people their own personal records, making it Internet capable, where they can bring that from physician to physician, hospital to hospital. We are also working with Dr. David Brailer while he tries to connect the entire system. So you are going to hear much from us on that issue, and I would be glad to provide more for the record.

Senator ENSIGN. Thank you.

Mr. Chairman, I apologize. Unfortunately, I do not have time to listen to your response. If you would like to explain it for the record, my staff is here and will relay the information to me. I appreciate your response, but I am required on the Senate floor. Thank you.

The CHAIRMAN. Thank you.

Ms. PRAEGER. Let me just expand on one area. In talking about the technology and the electronic medical records, there is a real opportunity there by making those medical records more easily transferred from treatment site to treatment site, avoiding unnecessary and duplicative tests. I mean how often has someone gone in for a sprain and an x-ray is done, and they go to the next place, the doctor says, "Well, I need to do another x-ray." Time after time after time those kinds of duplications of the service that does not add anything to the quality of the care that is going to be delivered. We can go a long way toward eliminating some of that if we can get those electronic medical records standardized, because unfortunately, what we have now are medical records being developed electronically and the ability for them to work in a facility, but then to be able to transfer that with any reliability and consistency to another location, another treatment location site, we are not there yet.

The CHAIRMAN. Thank you.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman. I want to thank Mitchell Blake. I am not going to ask him a question, but I ran a small business that—Mr. Rossmann, I had 800 independent contractors, so I know exactly where you are coming from, and I appreciate your testimony as well.

But these two ladies have been provocative on some of the negative side toward AHPs, so I want to ask them a few questions if I could.

First of all, Ms. Ignagni, your testimony was magnificent, and if I listened well, I got out of it that the two largest contributors to the cost of healthcare or some of our problems today, not necessarily in this order, are this whole issue of best practices and information sharing first, and second defensive medicine by virtue of the tort issue or medical malpractice. Am I correct there?

Ms. IGNAGNI. Yes, sir.

Senator ISAKSON. I happen to recently have had a situation where they were trying to figure out if anything was wrong with me other than mental illness.

[Laughter.]

Kept wondering, that so many tests seem to be run, that I wondered—I mean they were checking so many things out that did not hurt, bother me or anything else, it occurred to me there is a lot of defensive practice going on by virtue of the medical malpractice. Do you have a—and I know this is off the subject of AHPs and I apologize, Mr. Chairman, but does your organization have a recommendation with regard to medical malpractice and tort reform?

Ms. IGNAGNI. Yes, we do, sir.

Senator ISAKSON. What is it?

Ms. IGNAGNI. Three issues we think need to be priorities. First, we need to have caps because that has a salutary effect on how the

whole system works. The doctors are facing just the Sword of Damocles every time they see a patient, and they are worried about being able to practice medicine, and they do not feel they can practice medicine today. So if we remove that incentive and they have some certainty in the system, that will go a long way, number one.

No. 2, the safety legislation that has been working its way through the Senate and the House is very important as well. You want to give practitioners, hospitals and physicians, an incentive to report when things go wrong, so we can understand it, we can digest it, and they will not be facing the fear of lawsuit.

Third, we need to do a better job in developing alternative dispute resolution systems. The chairman has had legislation from last year that lays out a number of different alternatives. We very much are excited about contributing to that. We have learned a lot in the health insurance plan industry with respect to the value of external review. We think that external review, we can learn from that and we can transfer that and develop administrative procedures to take things out of the courtroom that do not need to be there in the case of malpractice. So it is a three-legged stool in our view. It is not one, it is not two, but it is three taken together that could really go a long way toward addressing this and freeing up some very important resources.

Senator ISAKSON. Second question with regard to the transparency issue, the information issue and best practices. Is HIPAA the biggest inhibitor to actually sharing information? And are the privacy laws we passed an inhibitor to actually getting best practice information out?

Ms. IGNAGNI. I wish I could say because that would be an easy fix. It is not. HIPAA actually gives us the ability to share data for healthcare operations, to actually be able to treat patients, so physicians can do that. The biggest barrier is not being able to diffuse all the things that are being developed in the research into practice quickly, and that is something that individuals—I will just give you one statistic that I think makes the point. We are spending roughly $30 billion in the National Institutes of Health. We are spending $300 million in the Agency for Health Care Quality and Research, $30 billion, $300. All the effectiveness analysis is being done in that $300 million. I think anyone could look at that in an objective way and say we need to do more in the area of effectiveness analysis so we can get that into the delivery system so we really deal with that variation that is going around in practice.

You know, you raised another issue, if I could just add, Senator, with respect to the incentive to do too much. We have seen now a real trend in the area of entities that have sprung up to encourage consumers to come in for full body CAT scans, etc., and we know that there is some real concern on the part of physicians, radiologist, about the implications long-term of that. We in our health insurance industry, as I talk about new strategies that we are reintroducing, we are looking at radiology and we are beginning to reassess the effectiveness of certain radiological procedures. We are seeing a very, very significant trend up in MRIs, CT, that really do not match with what we know patients need.

Physicians are concerned about it. We are working with the College of Radiology, and we are going to have some recommendations

on that, both for the private insurance system as well as for the public systems.

Senator ISAKSON. That is a subject I would like to have a discussion with you about. I know my time is up.

Could I ask one more question, Mr. Chairman? Would you be offended, Senator Burr?

Senator BURR. No.

The CHAIRMAN. You have always been my most cognizant one of the time, so have another question.

Senator ISAKSON. Thank you, Mr. Chairman.

I did not want to leave Ms. Praeger out. Ms. Praeger, you made a very declaratory statement, which if I wrote it down correctly was, AHPs will probably increase premiums. Would you elaborate on that statement?

Ms. PRAEGER. You all have focused on the real problem here, and you keep saying you are not talking about AHPs, but you really are talking about the real underlying problem, and that is the cost of healthcare services. I do not think an AHP can successfully provide over the long haul affordable premium coverage any more than any other group can, unless they just have a healthy population. So the concern with AHPs is that there will be a cherry picking in the marketplace and there will be a tendency to—for associations to form around groups that have a fairly low risk and leave those other entities in that group market to fend for themselves, and I think the CBO budget report that was I think in 2002, demonstrated that in their analysis that 20 percent may pay lower premiums, but 80 percent in the marketplace would probably be paying higher premiums. So that is the concern.

The whole concept of insurance is trying to keep as many people in the system without segmenting and isolating the healthy and thereby driving up costs for the unhealthy.

Senator ISAKSON. Thank you.

Mr. ROSSMAN. Senator, could I respond or follow up to that point that Ms. Praeger made?

Senator ISAKSON. Yes, sir.

Mr. ROSSMAN. I would just like to say I think that Ms. Praeger commented earlier about the creativity and the ideas that they are doing at the State level as far as forming purchasing pools and trying new and different ideas. One example of that is the State of Colorado, who formed a test association health insurance plan, which they said they were going to do I think 18 plans back in 2003. The concept behind it was you could have a fully-insured AHP program or association health plan at the State level, or you could have a self-insured program.

Well, our Colorado chapters, of which we have two, actually looked into the possibility of forming a self-insured association health plan under the Colorado State law. We came to find out it was about a quarter of million dollars in start-up capital to set up the self-insured program, and quite frankly, they just were not able to generate the activity, if you will, at the State level or the amount of revenue at the State level to start a self-insured pool.

Coincident with that, they started looking at all the different insurance carriers under this legislation to form an association health plan in Colorado that was fully insured. The bottom line of

that was that no insurance company wanted to get involved with an association plan because they were happy doing business the way that we are doing it today.

I bring this point up because—and I have checked with the insurance commissioner in the State of Colorado to verify these facts, that there are no self-insured AHPs under this test program which started January of 2004, and there are no fully-insured programs in existence today.

I bring this up because the whole purpose of the association health plan legislation is to take it to a little higher scope, to make associations, bona fide associations, purchasing pools on a broader level, to cross State lines and give the associations and the small employers the same economies of scale that large employers have. We feel that we have got the safeguards in the bill as it stands right now, we have got the protections to make sure that these types of plans when they start will be for the benefit of all small employers and will stay in business and make sure that the end result of providing health insurance for small employers is achieved.

But we welcome talking with the opposition or those that are opposed to the bill to see what things we can do constructively to make this a success for all small employers, because quite frankly, we realize it is not the end-all, be-all of solving the healthcare crisis. The points these ladies brought up today are probably very, very important, but we know from a functional standpoint and a practical standpoint that small employers are having a very difficult time now, and that the AHP legislation is an opportunity to provide them some relief as we use the programs and services and the technology that is being developed by the NIAC and also the health insurance companies.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Burr?

Senator BURR. May I inquire of the chairman, will we be doing one round of questions, or will we be doing multiple today?

The CHAIRMAN. We will go more than one round. I have quite a few questions left.

Senator BURR. That helps me. Let me thank all of our witnesses. It is good to see you, some of you whom I have had the opportunity to work on healthcare issues with before.

And Mr. Rossmann, thank you, you just stole exactly what I was going to say right from the start. This is a difficult thing because we are not here talking about how to solve the healthcare crisis. We are here trying to decide whether the right thing to do is to expand products that companies are screaming for across the country that may have affiliations that are desperately trying to continue to provide or to provide for the first time insurance for their employees.

I take to heart, Ms. Praeger, what you said about cherry picking, and I truly believe that if I was an employer and I cut back and cut back and cut back, those employees would look for another place to work where the insurance product covered what they wanted. I think we tend to leave the employee out of this, they are actively involved—and Karen, I agree with you about the esca-

lating cost of healthcare. I believe that we are the driver, the Federal Government, Medicare. The States replicate us. So does every insurer in the world.

The problem is that as we ratchet down reimbursements, so do the insurers, and consequently, so do the big employers turn to the insurers and they minimize the rate that their insurance goes up. There is cost shift, and an unfair portion of the cost shift today is going to the small group market. What they are experiencing as a percentage of increase on an annual basis is not being experienced by a General Motors. There is the ability to get a better price based upon the size of your company, and unfortunately, if we can do it right—and I believe we can and I am supportive of our efforts to do it—then we ought to allow small business to become a big business and to negotiate in the same volume, though we have to address some of the State concerns. We have to address some of the issues that are raised about the mandates, some of the issues that are raised about cherry picking.

Can we do it? Yes. We are smart enough to do it. I hope we can get past this and we can get back on the cost of healthcare and how we turn it around.

I commend your plans for bringing down the cost of prescription drugs. It is amazing what you do when you raise the copayment for a name brand and you lower the copayment for a generic drug. You save money because you have empowered the people who are participants in the plan to make a decision. We are talking about a section that does not have the choice. I think when we talk about transparency, if we are going to go there, then we have to seek full transparency. It means that every insurer out there has to be transparent. We have to know the rates they are negotiating. It cannot be a secret. That does not exist today. We all know it does not.

I think to some degree we are asked, Mr. Chairman, to be an arbitrator between people who naturally have to represent the constituency they have. I would ask all of you to forget that for a minute. Let us think about this group of individuals that are out there, the pool is growing every day of individuals who are employed and do not have healthcare, employed and cannot afford healthcare, employers that want to provide it and just cannot make the commitment financially that they always have. Understand, we have to find a solution to this.

I personally believe that AHPs are not a silver bullet. If they are a bridge that allows us to keep more people insured so we can get to the point that we solve the crisis in healthcare, then I look at that as a benefit, regardless of the amount of risk that goes along.

I want to ask some specific questions if I can. The first one would be, Karen, in your testimony you mentioned AHIP supports Federal seed money for State high-risk pools, though it is my understanding that some of the member companies were actually opposed to the creation of high-risk pools and were so vocal that States abandoned their efforts. Can you shed any light on that?

Ms. IGNAGNI. Right now 33 States have high-risk pools. They desperately need help in terms of a Federal helping hand and more funding. And we would like to see these kinds of strategies adopted

in all of the States as a backstop to what is going on in the market to provide opportunity——

Senator BURR. Is that a feeling shared by all of your members?

Ms. IGNAGNI. You know, Senator, to be honest, you can never say categorically that every member of a particular association supports that, but our board has taken an affirmative position last June, and we are reflecting that position. We have been working this at the State level to try to figure out how to comprehensively fund this. It exacerbates the problem if the answer to funding State risk pools just ends up on the backs of the private health insurance market, which means on the backs of working families.

So we have been pushing more broad funding, and that is probably where there have been some differences of opinions. No difference of opinion on the broadness of the funding, concerns about funding strategies that target the insurance industry particularly because that means employers, small employers, that means employees, that means working families. So that is probably where the different messages have come from. We are very much for broad funding.

I might say with respect to HSAs that there is some precedent here for the community to take advantage of in terms of learning and thinking about what you might do. Congress passed HSAs, as you know, as part of Medicare Modernization. There are still 10 States that have barriers actually to the sale of HSAs, so we have to address that. That comes down to the issue of regulatory harmonization and trying to figure out how to modernize our regulatory structure.

I deal with the mandate situation where small employers would like to do something. Sometimes the perfect is the enemy of the good. How do we get our hands around that? We have been working with the NAIC, and as I said, we are working with your colleagues on the other committees, addressing this regulatory issue. But it is a very real one.

Senator BURR. Well, representing a State where we never had the option to have MSAs because we never licensed a carrier that offered them, I understand exactly what you mean.

When we brought up the issue of Medicare Advantage Regions, what was AHIP's position on that proposal?

Ms. IGNAGNI. We are for the regions. We are for the local markets. We are for the frail elderly incentives, we are for the——

Senator BURR. But the effort was for less regions versus more regions.

Ms. IGNAGNI. Our efforts?

Senator BURR. Yes, marked for identification.

Ms. IGNAGNI. Our efforts were to try to get a political strategy and ultimately a regulatory strategy that would provide the most competition. And so we have been working with the Department to do that. We worked with you and your colleagues and the colleagues on the other side of the aisle to try to advance that as well.

Senator BURR. Having less regions would be a more nationwide approach than you talked about though, would it not?

Ms. IGNAGNI. Not necessarily. First of all, in terms of Medicare, what I am pleased to see is the number of contracts have now doubled in private sector participation since the enactment of the law.

That is 16 months. That is an excellent track record. So we are seeing a very fast growth.

Senator BURR. But fewer regions would mean more regional harmonization versus 50 different entities.

Ms. IGNAGNI. Not necessarily. You could harmonize with 50 States and indeed that is what, as we talk about regulatory reform, that a number of entities are talking about, both the NAIC as well as folks who are looking at insurance regulation broadly. The absolute number really does not drive the harmonization. It is the will to harmonize and modernize.

We are being challenged in the healthcare industry to operate on the principle of best practice. We think regulators ought to be challenged to do that as well. And so if you have 40 States can you harmonize regulation? Yes. If you have fewer States, regions, can you harmonize regulation? Yes. The question is having the political will to do it and getting it done and sorting through that and trying to figure out how to get it done as quickly as possible so we can be out there selling product.

One of the issues that we have found with the AHPs, we are prevented in many States from selling the kinds of products that small business would like to buy. That is a barrier. Do we fix that at the State level? Do we fix it at the national level? We are open to talking about whatever venue, as long as we can fix it so we can offer product for small players.

Senator BURR. Do you agree with my statement that more of the cost shift goes to small group plans today than to the larger companies?

Ms. IGNAGNI. I think that that is probably correct, but probably not to the extent you think it is. All companies now are bearing a significant burden as States clamp down on——

Senator BURR. But the fact is I do not know, do I, because there is nothing that tells me.

Ms. IGNAGNI. There is nothing that really tells you affirmatively.

Senator BURR. Mr. Chairman, you have been very kind. I will wait for the second round.

The CHAIRMAN. That means I get two turns now, right?

[Laughter.]

That is fine. Those were excellent questions. I appreciate the interest.

I am going to back up to a much more basic question that I need to have answered I guess. Do bigger companies get lower rates than small business? It seems pretty basic to the whole discussion. Do they?

Ms. PRAEGER. Mr. Chairman, let me just comment. Our State health plan in Kansas insures about 80,000 to 90,000 lives and we have an older State employee population, and we have the same health costs that would go with having an older population. When health insurance premiums were increasing in the double digits, we were seeing those same increases in our State plan. So even though we were large, the larger purchaser——

The CHAIRMAN. But that is talking percentages. I am talking actual dollars per employee. What I am hearing from small business is that they are paying more per employee than the big businesses are. Percentage of increase? Yes, everybody has got percentage of

increase. But if you start from a smaller base you still wind up with a smaller base. So is there a disparity in the dollars per employee with the smaller one? I mean intuitively it would seem that there would be because you are not talking about as many—you have more service you have to provide to fewer people, but is that true?

Ms. IGNAGNI. Senator, what I am particularly please—Ms. Praeger, were you finished? I am sorry.

Ms. PRAEGER. Yes.

Ms. IGNAGNI. Mr. Chairman, what I am very pleased about, we have just completed a study of the individual market which goes directly to your question, and I was very pleased to see the range of products now—and we can provide this for the committee's consideration—in terms of trying to hit this mark of affordability, both to the range of products in the individual market but then also what we see now being offered to small business. Now, with due regard to the fact that there are barriers in certain States toward offering lower option products, which a number of small businesses suggests that is the only thing that they can afford. But we are seeing products with premiums less than $100. We are seeing reasonable deductible, stop loss, catastrophic, beginning to be offered all over the country. And that has definitely increased from the last time we did this survey, which was about 4 or 5 years ago. So I would be delighted to provide that to the committee.

One of the things that I think with the AHP legislation that has not been understood, and admittedly, you could direct strategies toward fixing this problem, the AHP discussion always proceeds as if there would be this large pool that would be community rated. The AHP legislation does not propose that there be one rate established for every member of an NFIB chapter or an ABC chapter or something of that sort. Each of the businesses would be rated themselves. So with no rating bands, no guidance, you could have very, very significant swings in rates, which is why the CBO has indicated that 80 percent of individuals working in small business would probably have an increase in cost and why the actuaries—the other issue is the S&L problem. Basically you charter entities that have little experience in providing insurance, are not as capitalized as they need to be, according to the American Society of Actuaries, and then you have a real problem, which we have seen in the country.

The CHAIRMAN. But my question is: do bigger companies get a lower rate per employee than smaller companies do? I mean we are going from the assumption that they do, and I think it is true, but I want to ask the question.

Mr. Rossmann, did you want to comment on that?

Mr. ROSSMAN. Yes. Senator, I would say from my personal experience that they do. Larger companies get a better rate than smaller companies for two reasons. One is in the administration cost and marketing and sales cost that a insurance carrier will charge to a larger company versus the expenses factors in cost in selling to a smaller company. That is a savings right there.

The other tool I guess you would say to get a lower rate for larger companies is the fact that they have experience rating. In other words, the premium dollar they pay into the insurance company is

counted for against the administration charges that the insurance company makes, plus the claims charges of what they pay out. And generally any difference, if there is a margin in a given year, where they pay in more premium than they have paid out in claims and expenses, that dividend goes back to the benefit of that large employer to reduce their rates in the future. That is called experience rating. It is a standard industry item. So they get a dividend back from the insurance company.

So by virtue of that, large employers also have lower cost or lower rates if you will for their insurance coverage. That is one of the big things of an association health plan. Under an association health plan the trust that is set up with trustees or fiduciaries under the program would be able to have an experience rated program, where any margins that are generated in a given year, if there are margins—and granted those are getting fewer and fewer because health costs keep going up and up—but if there are any margins those margins stay in the plan for the benefit of those little employers this year and next year.

The CHAIRMAN. I think when people are advocating a larger pooling solution for the small businesses, they are looking for a short-term solution, and what we are talking about on some of the other solutions are long-term solutions. But the long-term solutions affect the big companies just like they do the small ones. The med mal is a problem for everybody in the country, it is not just the small companies. The risk spreading, the mandates, those are all problems that the big companies have as well. But the people advocating the AHPs are talking about a short-term solution, hopefully that will turn into a long-term solution.

I want to talk a little bit about the mandates. States have mandates. One of the things that shows up in some of the legislation that I have looked at that I will get to referee on is elimination of some of the State mandates which would bring down some of the prices. Would there be savings if there were greater flexibility in designing the benefits if there was nationwide some kind of a change in the mandates? Mr. Rossmann?

Mr. ROSSMAN. I think if you have some consistency across State lines—and that is what you would basically achieve through the association health plan legislation—and it is a modification of—it is giving small employers the same advantages that large employers have today.

One of the interesting issues is the fact that if you formed an AHP and you set up this plan and it was a very rich plan or a very bare bones plan, it would still have to go out to the open market and it would have to be sold, I guess you would say, to the small employers who were members of that association. And those employers have a chance to buy that benefit if they wanted to or not buy that benefit.

We have seen over the years that bare bones plans with low or no mandates basically have not sold. I can tell you from personal experience and ABC members, they want quality benefits to offer their employees just like the large employers have for their employees in order to attract and retain employees. So we do not provide programs that have low benefits, I guess you would say. They have quality benefits and good comprehensive coverage.

I guess the other thing I would mention on mandates and rating under the AHP provisions, the AHP bill, the bill is designed to have the experience rating of that association come up with one set of rates, if you will, for the association in general, in other words will base the rates on the experience of the association, take into consideration age rating, geographic rating, sex, family composition, all the types of things that States and insurance companies do today nationwide. And then deviate those rates upward or downward only to the extent allowed by State law, and that is written right into the bill for both insured and self-insured programs.

So the AHP would be operating within the rating bands of the various States. In other words they would use their age rating to come up with a set of rates for the firms in this State, but then either raise them or lower them if allowed by the State, and if the State did not allow it, a State required community rating, then they would use those rates to develop a general community rate for that State and those employers.

Ms. IGNAGNI. Mr. Chairman, that—and I appreciate what Mr. Rossmann said, and I may have a wrong understanding of the legislation, and I apologize if I do. One of the problems that Mr. Rossmann has correctly talked about is this issue of what does an individual employer pay, and that is Senator Burr's question too. And unfortunately, I think, a number of individuals that have sought to support AHP legislation have talked about it as one rate, federally-chartered AHPs, very few standards, preemption of mandates, etc. Unfortunately, what that would mean is an experience-rated premium would be asked of Mr. Blake. So his situation could be exacerbated under this particular legislation, which is why CBO gets to where it is with respect to its analysis of who would be the winners and who would be the losers.

So with all due respect, our community wants to be a solution provider. We want to help you sort through this. Although we also at the same time wanted to be honest about issues that we say with respect to unintended consequences with legislation that could be pushed for meritorious reasons, but could have a serious negative consequence on small business such as Mr. Blake's.

The CHAIRMAN. I understand that. What we are trying to do is drive toward some solutions that will solve Mr. Blake's problem in the short term.

Ms. IGNAGNI. Well, I think you really then have to get to the situation of how do we sort through this patchwork quilt at the State level with respect to different rating requirements, different solvency issues, different mandates, the inability to bring products to market quickly. There are a whole range of issues that need to be honestly and legitimately sorted through. We would like to help the committee do that and provide some answers. But it is not—we believe the wrong strategy is to carve out a particular group with no experience in the insurance market with little capitalization to say let us develop a Federal corridor for them, because the unintended consequences we think are going to be quite severe, and we have had precedent for those unintended consequences.

The CHAIRMAN. We will appreciate the cooperation and the help on that.

Senator Burr?

Senator BURR. Mr. Chairman, I sat here at the beginning of your process with the thought that if we were sitting in a Banking Committee meeting we would be talking about an inverted curve. In fact, in North Carolina today, for an employee of a small business it is actually cheaper to buy an individual health insurance policy, than it is to be a member of a small group. That tells you in a pretty good sense that the small group market is pretty messed up, and I think that experience cannot be limited just to North Carolina, and that to some degree shares with you the frustration.

When employers cannot offer, cannot negotiate, cannot find an insurance product that they can provide for their employees that is cheaper than what the employee could go out in the open marketplace and get a policy for—and by the way, that individual who goes out in the marketplace can assemble that policy in all likelihood custom to them. They can decide what the deductibles are, they can decide what the copayments are going to be. They can decide so that they can match the premium where they personally need to be. The likelihood is that a small group plan does not have near the flexibility because they are trying to address a larger population.

Again, I think it is a sign that something is broken. I think the chairman has committed to take up legislation. I am committed to make sure these employees have additional options. Where there are places that we can fix a bill, we have to do it, but my concern is that right now the small group market is the first one to feel the excesses of the cost of healthcare as it rises, and they are the last ones, if at all, to feel the benefits when we get it under control.

The only way to let them feel the effects that big business does today is to in fact give them additional tools that give them a way to compete in a marketplace through leverage. Whatever that is, I think that is where we are trying to get to, so I encourage all of you to continue to help us as we go along through this process to try to put together legislation that I think makes sense, but also heads in the direction that I think all of us here today are concerned about.

Mr. Rossmann, I wanted to give you one more opportunity, if you choose to, to address the cherry-picking issue and the rating pool issue. You did just follow up on the rating pool, but I think that consistently, regardless of what conversation you are in, when AHPs are mentioned and if there is somebody who is not in favor of them, the first word out of their mouth is, "Well, they are just going to cherry-pick." The second phrase out is that "This is going to have an effect on rating pools." Will you address both of them?

Mr. ROSSMAN. Thank you, Senator. I appreciate it. I would be glad to.

As far as the cherry-picking issue, I think at this point that is a moot point, basically because the bill provides that it must be established, the AHP must be established by a bona fide association, it has to have trustees who are all fiduciaries, like you have fiduciaries under union and corporate plans, and they have to set up a separate trust which is acting in the best interest of the participants.

Also the bill specifically requires that membership in the association cannot be conditioned on health issues or health concerns. In

other words, you have to let members into your association like you normally would. You cannot say, "I am only going to let the healthy members in the association and forget about the people that are unhealthy." So membership is not linked to health status.

It also says that under the association health plan the trust or the program must offer the benefits to all eligible members. The only difference I can see in a place where you would not have an eligible member is quite possibly if you got an HMO option in some part of the country and the HMO service area does not expand to the entire Nation, you may not be able to offer an HMO to somebody in Wyoming when you only have it available here in the DC area. But other than that, if you have got PPO programs, preferred provider type organizations, that you have nationwide, you should be able to offer the same programs to all employers and all employees across the country, and that is the concept.

So there will not be cherry picking because all employers have to get in. There will not be cherry picking because you cannot deny coverage for an employee. Quite frankly, I feel personally, and what we experience day-to-day at ABC, is the people that are looking for an association health plan tend to be the people that have medical problems, the people that are having a hard time with their insurance. Those are the folks we get a call from every day at the office, asking if we have an association health plan that they can get into.

So I think the cherry picking could be almost reverse cherry picking and the people that are going to want this program when it is passed would be the folks that need it the most. We have to make sure that we get all of the members into that.

So I hope that answers the issue on cherry picking. It does not exist because you cannot coincident health status on membership, you cannot deny coverage to the employers, and you cannot deny any specific employee. So those three factors eliminate cherry picking.

As far as rating goes, I did not mean to—and I apologize if I did—I did not mean to say that there would be one rate nationwide as far as the rating goes. What we would do is we would have one large pool of plans and rates in which Mr. Blake would participate, for example, and those rates would vary according to the plan design. It would use age rating. It would use family composition, sex, all the things that insurance companies use today. And we have a set of rates for each medical plan, and those rates would vary according to the area of the country you lived in.

And then we would say those are the rates for all the employers of ABC, but oh by the way, if you have some employers that are not quite healthy, the plan can rate you up only to the extent that is allowed by State law in which the employer is located, which is saying we are trying to put the AHP on an equal footing with insurance companies. We do not want the AHP to be in a position where the insurance companies can rate up and the AHP could not rate up to that level in the State, and then all of the business that has high medical rates would come to the association health plan. So we are looking for parity there, and that is specifically stated in the bill.

The advantage in this experience rating of this pool is you bring all these claims and expenses back together and you say at the end of the year, our costs were X number of dollars for the entire group in the AHP. We need a rate increase of X percent for the next year, and then everybody in the country gets that same rate increase. We pooled them all together for experience. We pooled them all together for plan designs and the benefits of margin if it is good experience, and for rate increases if it is poor experience.

So in this situation under this concept Mr. Blake would have the same kind of increase that everybody else in that AHP had in a given year. He would not be—I should not say lasered out—but he would not be focused on with huge rate increases because you are pooling them all together, and that is the concept behind the association health plan.

Senator BURR. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

This has been helpful. Like I say, it has raised a lot of questions. The purpose of the hearing is not to go any particular direction, but to find some series of ideas which a task force that I served on last year came up with, that would perhaps provide some relief to small business as quickly as possible. Then there is a whole series of issues that we have been working on that would provide help to all businesses. Those are a bit more difficult to achieve, but we have had some success already. Health savings accounts is one of the things that we had on the list. Those are in existence.

I have to tell you though when those first came out, my son's business was in the process of looking for some insurance and I had told him what this could do. So as he interviewed insurance people he asked them about health savings accounts, and all of them said, oh, that is a terrible idea, should never have been done. And he called me up the night after he did those, and he said, "Dad, you must have done something wrong." I said, "Why?" He said, "Well, the companies all tell me it is a bad idea." I said, "Well, here is the key question to ask them. Ask them if they have a health savings account." He did. Not one of them did have. I said, "Well, if they do not have the product, of course it is a bad idea." Six months later when I talked to him about his insurance, he said, "Yes, we have health insurance plans by almost every company now and they are pushing them."

There are some solutions out there and they have to be worked on very carefully and put into place, and I am hoping that everybody will participate in those. One of the things I am doing on all of health is trying to sit down with the different groups—health insurance companies would be one of them—and ask them what they can do to help.

Of course, the first thing that always comes out is if the doctors did better practices, if the lawyers did not sue, and I say, "No, no, no. My question is what can you do to bring down the cost of health?" I have got all the finger-pointing ideas already and we are working on things in those areas to eliminate that, but even the consumer can do things that will help bring down the cost of health while we increase quality and access. That is what we are trying to do, so we will try and be careful with all of it, but hope that all of you will continue to come up with ideas, and maybe out of this

whole thing there will be a hybrid that will work, and it will work with the State insurance commissioners still in the position where they can do the good work that they do, and I am pretty sure that under any scenario that we do, the insurance companies that are in place now will be a part of whatever happens. They may be administering associated health plans, but they will still be there.

We will try and be careful on the whole thing.

Again, I appreciate all of the testimony, and the record will remain open.

This hearing is adjourned.

[Whereupon, at 11:38 a.m., the committee was adjourned.]

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